THE POLITICAL INFLUENCE OF THE AMERICAN MEDICAL ASSOCIATION, 1945-60

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by

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G. Five Minutes-Fifteen Points: A Short Talk for Public Audiences on Health Care for the Aged.

INTRODUCTION

The first chapter, Origins of the American Medical Association, is presented only for the purpose of a cursory review of the medical profession. No proliferation of details is intended. In the second chapter, Functions of the American Medical Association as a Pressure Group, an effort is made to show how the machinery is implemented for the purpose of influencing legislation as it relates to health. Pressure groups, be they labor, business, or management, try to influence legislation in their favor. The activities of any pressure group or set of pressure groups constitute what sociologists call a system. It is through this system that political aims are pursued. For more than a decade organized medicine has fought off attempts by the government to bring it under federal control. The medical profession has, for the most part, been successful. On the following pages an attempt will be made to show how the A. M. A. and its allies work in trying to influence legislation, how this influence is achieved, and what methods are used. It will be shown how pressure is brought to bear on public officials at all three levels of government. The third chapter, Campaigns of the American Medical Association Against Government-Sponsored Health Legislation, 1945-1960, is a follow-up to the second chapter--the main difference lies in the

attempt to influence the rank and file citizenry of the United States.

Since this study concludes with the year 1960, Appendices B-E are presented for the purpose of reviewing health legislation from 1961-65.

CHAPTER I

ORIGINS OF THE AMERICAN MEDICAL ASSOCIATION

During the first half of the nineteenth century, there were numerous attempts made to upgrade the medical profession. States such as Massachusetts, New York, Pennsylvania, and Ohio had taken steps to insure regulation of medical practice. Before 1830, several states required prospective doctors to be licensed by a state medical board. However, these laws, where they were on the statutes, were rarely enforced. The condition which prevailed was such that anyone could practice medicine. The school which raised its standards was vexed by a loss of students to the more lax schools. The question that arises here is whether or not it was better to have quantity or quality. The dominant thought throughout much of the nineteenth century seemed to be one of quantity. It was more desirable to have doctors who were at least acquainted with medicine than a few who were well qualified. It is readily seen that prior to 1847 attempts for a nationwide organization were unsuccessful. Public distrust and professional apathy contributed to the destruction of these early attempts to organize.

In 1845, N. S. Davis began a campaign to insure a successful permanent national organization. The Medical

Society of New York, of which Davis was president, invited all medical schools and all medical societies to send delegates to a general meeting designed to correct the inefficiencies in medicine. The first National Convention, which met in New York in 1846, accomplished little. This Convention resolved,

> That it is expedient for the medical profession of the United States to institute a National Medical Association for the protection of their interests, for the maintenance of their knowledge, and the extension of their usefulness....[1]

The Convention of 1846 also delegated committees to formulate an outline for a national organization. It was further resolved that another National Convention would meet the following year, 1847, to discuss the committee reports. Philadelphia was selected as the site for the convention.

At the Philadelphia Convention in 1847, more than 250 delegates representing 24 states met and promptly adopted the outlines and by-laws presented by the committees. The rapid adoption of these recommendations reflects, I think, two things. One, the recognition of the urgency for

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[1] D. E. Konold, A History of American Medical Ethics, 1847-1912 (Madison: University of Wisconsin Press), 1962, p. 8.

an organization that was national in scope to combat medical charlatans and two, the long period of time in which such an organization was not in existence. Thus, the American Medical Association (A. M. A.) was conceived. Dr. Nathaniel Chapman, first president of the Association, stated that "...it (A. M. A.) comes forward in the majesty of its might to vindicate its rights and redress its wrongs."[2] Dr. Chapman further stated that the Association could always "clean its own house." In short, no outside or lay interference. Thus, from this statement, emerged the underlying philosophy of medicine. The A. M. A. has clung tenaciously to the belief that it knows what is best for medicine.

The first annual meeting of the A. M. A. was held in Baltimore, May, 1847. It was reported to have been a cordial meeting, with a great deal of rapport and an effervescent enthusiasm shown for the advancement of the profession. Regulations governing the meetings were based on the following:[3] Each local society was entitled to one delegate for every ten regular resident members and for "every additional fraction of more than one-half this number." Two delegates were allotted to represent the faculties of duly constituted schools of medicine. Two delegates were

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[2]Konold, Ibid. p. 9. Brackets mine.

[3]"American Journal of the Medical Sciences," Vol. XXX (April 1848), p. 578.

to represent the professional staff of chartered hospitals containing one hundred or more patients. And one delegate could represent other permanently organized medical institutions that were in good standing.

The A. M. A. was established for several reasons---to support scientific investigations, improve professional solidarity, and most important, to improve the standards of medical education. Prior to 1847, there was a profusion of medical schools, with many being of an inferior grade. The formation of the A. M. A. did little to curb the growth of these schools. In fact, the number of low quality medical institutions was greater in the post-1847 period than in the pre-1847 period.[4] The American Journal of the Medical Sciences, beginning in 1848, published from time to time this information on medical schools. A study of these tables would reveal that the growth of substandard medical institutions did increase during the second half of the nineteenth century.

Most of these new schools were private whose primary purpose was to acquire money. Though the A. M. A. had adopted its Code of Ethics in 1847, the schools were, for the most part, oblivious to standards of ethics. Diplomas

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[4]See Appendix A for the number of students and graduates in most of the medical schools for the year 1846-47.

could be obtained in a matter of weeks with a minimum of instructional background. Graduates of bona fide medical schools protested in vain. It seemed that the population boom demanded a quanity of doctors, not necessarily quality. The laissez faire doctrine of free competition was no less applicable to medicine than to any other facet of society. Hence, people from all phases of the working class - planters, quacks, factory employees, and mid-wives - had a hand in cure-alls. Between 1847-1900, there was little research. Though the A. M. A. supported scientific investigations, it was either unable or unwilling to subsidize such endeavors. If any research was undertaken the individual responsible for it had to pay the cost out of his own resources.

The Association early opposed all sectarian groups and concentrated on removing all non-conformists from its ranks. The years 1847-1900, then, were wrought with internal dissension and the organization of opposition groups. Consequently, with the stress on adherence, the A. M. A. and other like medical societies failed to accomplish anything noteworthy. The Association was particularly vehement towards homeopaths and eclectics. This feeling was so strong that the progenitor of the A. M. A., the New York Medical Society, because of its alleged connections with homeopathic groups, could no longer send representative

delegates to the A. M. A. This disassociation between the two is perhaps the reason for the strained relations today between the state of New York and the Association.

Of special concern was the rapid rise of specialization and the establishment of societies to represent these new areas, i.e., American Dermatological Association, 1876; the American Surgical Association, 1880; American Otological Society, 1867; and the American Neurological Association, 1875. These societies of specialization, more than any others, posed the greatest threat to the A. M. A.

Twenty years after its founding, the Association had not made any significant gains toward consolidating its purposes. The Committee on Medical Education stated that efforts in this field had "failed to produce any very important practical results...."[5] However, the A. M. A. was not divided by the Civil War as were other groups. The Association was in the forefront of reform movements after the war despite its internal dissension. It could handle major problems and still remain intact. As a scientific organization, though, it was among the reformers with limited objectives. The A. M. A. took no stand on the prohibition issue, and maintained a weak voice in tenement condi-

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[5]"The Transactions of the American Medical Association," Vol. XVIII (Philadelphia, 1867), p. 363.

tions, misleading advertising, and food adulteration. The medical profession did not want to endanger what little unity it had been able to achieve. It was still in the process of establishing a firm foundation and was fearful of spreading itself too thin.

For half a century the A. M. A. was retarded in its growth, aside from those already mentioned, by a confederate form of organization, an inadequate constitution, and no encouragement of research due to a lack of subsidy. Further, it was an unchartered association, with no board of trustees until 1882 and with no national headquarters. The American medical literature was inferior and lacking in originality. A great deal of plagiarism existed in terms of Americans editing books printed by the British medical societies. This was rectified by the publishing of the Journal of the American Medical Association in 1883,[6] and the passage in March, 1891, by Congress of an international copyright law.

Thus, at the end of fifty years, the position of the A. M. A. was less than secure. The Association did not speak for all of the medical profession in any section of the country. Though it was stronger than any other medical society at this time it had not become the voice of physicians.

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[6]Hereinafter cited as the Journal. In footnotes it will be cited as JAMA.

Clearly, if the A. M. A. was to become the physician's spokesman and if it was to be the controlling factor in medical practices, there was a need to reorganize.

> ....a vast number of incompetents, large numbers of moral degenerates; crowds of pure tradesmen, blatant demagogues; hospitals organized and conducted to the damage of profession, patient and people; ....medical colleges organized for the advantage of the few at the expense of the many...; medical societies so conducted ...to advance the financial profit of their leaders; domination by common interests of drug manufacturers....[7]

Thus, Dr. Leartus Connor summed up the conditions of medicine and its related fields at the turn of the century. This quotation serves to amplify the rapidly deteriorating conditions of American medicine. Truly, the need to reorganize was justified.

The A. M. A. was, from 1847-1900, a confederation made up of local societies who were represented by delegates. It also consisted of invited members and, by this time, a permanent secretary, W. B. Atkinson. This form of organization was adequate in 1847, which, at the time, consisted of only a few local societies and only 25,000 M.D.

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[7]Journal of the American Medical Association, Vol. XXXII (11 Feb. 1899), p. 273.

certificates. By 1899, the number of local societies had grown to 1,300 and the number of M.D. certificates had swelled to 120,000.

Shortly after the 1870's, it had become apparent the A. M. A. had failed in its purpose. History has shown that those who acquire power are reluctant to relinquish their position. This was no less true of the executive heirarchy of the A. M. A. Those who wielded power had entered a monotonous, conservative routine. There was little or no regulation of the country's hospitals, particularly in the realm of fees. The January 3, 1901, edition of the New York Times printed an article concerning the Bellevue Hospital of New York. Doctors began to denounce the hospital's administrative policies in terms of assessment. They accused them(administration) of extorting money from indigent people under the threat of being committed to an asylum. As conditions regressed from bad to worse, younger, more liberal men within the power structure began to think and talk of reorganization. The first movement toward consummating this end occurred in 1866 but was defeated by the conservative element. Then, in 1889, Secretary Atkinson retired under mounting pressure and was succeeded by G. H. Simmons. The removal of Atkinson was the last major obstacle to be cleared toward reorganization.

In 1901, the present-day federal plan of organization was adopted. The A. M. A.'s representative body, the House of Delegates, assumed the responsibility of the Association's business affairs. The ten sections of the Scientific Assembly divided their technical interests into delegated areas of concentration. The Executive body was in the form of a Board of Trustees. Lastly, dues became uniform, the constitution was altered, there were stronger ties with county and state organizations, and there was "unity in a trinity." The result of this change produced a centralized, yet flexible authority. By 1905, membership in the A. M. A. had risen to 45,000. Also, a Medical Directory was compiled in 1905 and in that same year the A. M. A. began to incorporate the special councils, i.e., Physician and Surgeon's Council. By the early 1930's, the Association had a membership of 62,000 and the Journal boasted a circulation of 82,000.

The A. M. A. was established as a scientific and social group and still functions in this capacity. Article II of the A. M. A. Constitution states that the Association's objectives are, "to promote the science and art of medicine and the betterment of public health."[8] Though the A. M. A.'s goals are better health for all people, it has expanded

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[8] News Department Release, A.M.A. Chicago, Illinois, 1962.

its sphere of influence. In the beginning, the Association was a non-profit organization but it is now a potent business and trade association with an annual treasury in excess of 20,000,000 dollars. In 1962, 46.6% of the budget came from advertising in A. M. A. publications; 28.1% from membership dues; 13.0% from outside subscriptions; 5.8% from miscellaneous sources; 3.4% from investments; and 3.1% from the sale of exhibit space at meetings. In 1962, 198,000 physicians out of 271,000 in the United States held membership in the A. M. A. Percentage wise, this would be 73% of the nation's doctors.

The other areas of endeavor on the part of the A. M. A. will be more fully explored in the following chapters.

CHAPTER TWO

FUNCTIONS OF THE AMERICAN MEDICAL ASSOCIATION AS A PRESSURE GROUP

William A. White once commented that,

> The ruling classes are those who use their craft societies, medical associations, farm bureaus, labor unions, banker's associations, women's leagues, and the like to influence government.[1]

Although the A. M. A. is often cited as one of the most influential pressure groups, it did not acquire this position until the post-W. W. I period. The Journal stated that, "The A. M. A., during the first fifty years of its existence, exerted relatively little influence on legislation, either state or national."[2] In the beginning the Association's political interest was limited to agitating for adequate vital statistics legislation and expanding the role of the federal government in areas of public health. Today, the position of the A. M. A. towards government expansion into medicine is just the opposite to that of the nineteenth century. This reversal in attitude is traceable

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[1] W. A. White, Politics: The Citizen's Business (New York: MacMillan Co., 1924), p. 15.

[2] JAMA, XXXVI (8 June 1901), 1601.

to the status of the Association. In its formative years the A. M. A. lacked a solid foundation and consequently was an impotent political machine. Also, the political atmosphere during the last half of the nineteenth century was such that the A. M. A. had little to fear in the way of government overexpansion into social welfare. As the Association grew more potent it realized the only way to achieve its desired ends was through the acquisition of political power. Thus, from the 1920's to the present time, the A. M. A. has continued to further entrench itself in American politics.

The first real campaign of the A. M. A. that had political overtones was in 1893 in the struggle for a federal department of health. This health department would have secured the following information: (1) collected statistics on sanitation from state and municipal authorities from which a weekly abstract would be published; (2) required more adequate registration of vital statistics; and (3) provided for the collection of information about the climatic conditions of the nation and its effect on health. This bill, however, was not passed by Congress. Though the A. M. A. failed to exert any legislative influence during the nineteenth and early part of the twentieth century, it nevertheless gained invaluable political experience.

The Association began, in the 1890's, to stress the idea that a machine was needed through which it could effectively implement its goals. In 1899, the establishment of the Committee on National Legislation was a step in this direction. This committee held meetings to determine political developments and, based on their findings, set forth the A. M. A.'s strategy to cope with the existing situation. It also urged local societies to take an active part in politics and further recommended that doctors seek legislative positions.

The Committee on National Legislation, along with the National Auxiliary Congressional Committee, had the responsibility of presenting the interests of the profession before state legislative bodies and Congress. This was to be done, "by every honorable means, personal and political, individual and professional, private and public, direct and indirect."[3] The efforts on a state and local level were to be reported to the state society's legislative committee. Those efforts to influence legislation on a national level were to be reported to the chairman of the Committee on Medical Legislation. Thus, definite channels were established which lent themselves to the development of an effective political pressure group.

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[3] JAMA, XLII (11 June 1904), p. 1577.

In 1903-04, the A. M. A.'s Committee on Medical Legislation set-up a register of local political leaders in all recognized parties. By 1905, this list amounted to 11,000 men from 900 counties. To accompany this, a brief summary was given on the political climate in each area. In this way the A. M. A.'s rank and file members could get in touch with these local political leaders, establish rapport, and discuss pending legislation. From all indications this method had a high degree of success. However, by 1910, one change had taken place. Rather than a direct appeal to political leaders, the A. M. A.'s views were presented at medical meetings and these were then channeled through the proper legislative body and/or committee.

In January, 1907, another branch of the A. M. A. was organized to further consolidate its efforts to influence legislation. The Bureau of Medical Legislation, as differentiated from the Committee on Medical Legislation, was given the task of collecting information on medical practice arts, collect and analyze federal and state supreme court decisions on these acts, frame a model vital statistics bill, secure information on pure food and drugs legislation, and review other state health laws. Though its purposes were admirable, the Bureau was less than totally effective and was therefore abolished in 1912.

To complete the above goals, the A. M. A., in 1913, organized the Medicolegal Bureau. This Bureau re-wrote the model vital statistics bill, prepared a series of model health bills, and completed laws on public health matters. In furthering the A. M. A.'s attempt to build a complete, compact pressure group, the Medicolegal Bureau established a mailing list of prominent men in other professional organization, i.e., American Bar Association, and officials on all three levels of government, local, state, and national. It also contacted legislative reference bureaus in the forty-eight states, now fifty, to discuss, jointly, public health. Perhaps the Medicolegal Bureau's most important accomplishment was the publishing of The Digest of Supreme Court Decisions on Medical Practice Acts, whose purpose was to make doctors aware of certain pitfalls to avoid in the practice of medicine.

In the first two decades of the new century only twenty-seven physicians, none of whom reached a high degree of prominence, served in the United States Congress. If the success of the A. M. A. during the years following reorganization is to be measured by the number of men it placed in Congress, then it can be concluded the Association did not achieve its aims. It is obvious, however, that success is not contingent on any one factor. The med-

ical profession did succeed in establishing a political machinery through which it made its aims known, though the strength of this machine is open to question. The first twenty years of the twentieth century firmly entrenched the A. M. A. as the voice of doctors. In 1913, the membership was enlarged to include all members who were in good standwith their local and state societies.[4]

Thus the years following reorganization to 1920 can be summed up as those years in which the A. M. A. was recruiting members, establishing a cohesive association, building a political machinery through which it could influence legislation, and establishing itself as a potentially potent pressure group.

The termination of W. W. I also ended the Progressive Era, in which the A. M. A. played a dubious role in promoting health legislation. The medical profession stated its opinion on some health measures while on others it remained silent, i.e., tenement housing with its attendant health problems. One of the most pressing problems in terms of health during the 1920's was infer-

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[4]The term "fellows" was applied to a physician who was in good standing with a local society, applied for membership into the A. M. A., subscribed to the Journal, and paid the annual dues(which amounts to $125 today).

ior food. The uncovering of harmful effects due to certain food preservatives by Harvey W. Wiley, the publishing of The Jungle by Upton Sinclair, and the struggle against false patent medicines led the A. M. A. to form alliances with other organizations, i.e., Women's Christian Temperance Union and the federated labor organization. Together they campaigned for a national food and drugs act. Their efforts were not in vain, for on June 30, 1907, President Roosevelt signed into law the Pure Food and Drugs bill. An editorial in The Journal of the American Medical Association stated,

> The law is far better in every respect than its most ardent supporters could reasonably have expected. When we consider the determined and able efforts which have been continuously made by the opponents' wealth of expert testimony which has been advanced against it, we must confess to a feeling of grateful surprise that the measure is as strong as it is.[5]

The end of W. W. I saw a change of attitude on the part of the A. M. A. toward government interference. In 1900, with only 8,400 members, the Association was weak and insecure, as has been mentioned, and sought federal assistance. In 1920, fortified by a membership of 83,000 the

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[5] JAMA, XLVII (7 July 1906), p. 41.

A. M. A. saw in the federal government its greatest threat. The plan to grant veterans' benefits in particular gave rise to this suspicion. Another threat was the federal government's plan to subsidize state health programs that were concerned with infant and maternal care. However, the dominant issue during the post-war decade was the prevention of a compulsory health insurance plan.[6] In May, 1922, the speaker of the House of Delegates commented, "Compulsory health insurance never will and never can become an American institution."[7]

The Association did not enjoy the success in the 1920's and 1930's that it did from 1940 to the present time in defeating health legislation. In November, 1921, Congress passed the Sheppard-Towner Act despite objections from the A. M. A. This act set aside federal grants to help finance state welfare programs for infancy and maternal care. The World War Veterans' Act of 1924 also became law in spite of the medical profession's negative attitude. Specifically, the

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[6]According to the majority of medical historians the real struggle against compulsory health insurance did not begin until the late 1930's.

[7]House of Delegates, Proceedings (73 Annual Session, May, 1922), p. 2.

> act allowed veterans of all military occupations and expeditions since 1897 with nonservice-connected disabilities the use of all beds in veterans' hospitals that veterans with service connected disabilities did not occupy.[8]

The A. M. A.'s main objection was to the availability of goverment medicine to those veterans not disabled in the service. The Association felt this would detract from private practitioners and add unnecessary taxes.

> Through paragraph 10 of section 202 of the World War Veterans' Act of 1924, the federal government planted the germ of state medicine in our body politic and entered directly into competition with the private practitioners and private hospitals of the country.[9]

When Congress passed the Sheppard-Towner Act in 1921, it set a limitation date--June 30, 1927. The A. M. A. fought against a two-year extension of this act. Doctors were urged to write the President, their Senators, and Representatives in an effort to defeat the two-year measure. Congress was unswayed by these efforts and in the spring of 1927 voted to extend the Sheppard-Towner Act.

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[8] J. G. Burrow, A. M. A.: Voice of American Medicine (Johns Hopkins Press, 1963), p. 159.

[9] JAMA, LXXXVI (23 Jan. 1926), 278.

In 1930, President Hoover held a White House Conference on Child Health and Protection. Part of the final report of this Conference reaffirmed the need for an increase in federal appropriations for state health programs. This report was submitted to the President despite objections by the A. M. A. The following year, 1931, the Senate passed the Jones-Cooper Act which simply amplified the principles of the Sheppard-Towner Act. Although the House failed to pass the measure, it does show that the medical profession had limited success in influencing legislation.

The small amount of success by the A. M. A. is related, in part, to the unwillingness to reconstruct the legislative machinery that was organized during the first two decades of the twentieth century. The pressure which the Association had been able to exert diminished considerably. Another contributing factor to their lack of success was the uncooperativeness of many local societies. When the A. M. A.'s Bureau of Legal Medicine and Legislation attempted to secure information dealing with health measures that were before various state legislatures, it was met with resistance by several constituent societies. Also, state organizations did not receive any degree of aid from the A. M. A. in exerting pressure on state legislatures. Thus, during the post-war period the A. M. A. was politically active but met with some resounding defeats.

At the start of the new decade, 1930, the picture was clouded by the depression. Although the A. M. A. voiced opposition to compulsory health insurance and to group hospitalization, and attacked the Committee on the Costs of Medical Care,[10] the Association did not produce a plan of its own. The medical profession clung stubbornly to time-worn practices and forms of payment for meeting the health needs of people.

The election of Franklin D. Roosevelt to the Presidency and the subsequent emergence of the New Deal caused many people to speculate as to what position, if any, the A. M. A. would take. The Emergency Relief Act, which made federal funds available for the indigent who could ill afford medical costs and where local resources had reached a minimum, was actively supported by the A. M. A. The medical profession provided the necessary service and shared the responsibility for adjusting fees.

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[10] In 1927, eight philanthropic foundations organized a committee to study the health needs and available resources of the nation. The study took five years to complete. Part of its final report showed "...the inadequacies and inequalities of medical and hospital service, and the inability of a large percentage of the population to purchase it." The report further recommended the adoption of group payment "through the use of insurance, through the use of taxation, or through the use of both those methods" to aid in medical costs.

The A. M. A. also supported the Civil Works Administration. Under the United States Employees' Compensation Act, 1916, employees of the C. W. A. were eligible for medical care supplied by funds from the government. The federal government and the A. M. A. worked together, along with local societies, to solicit aid from physicians to treat injuries resulting from employment in the C. W. A.

Finally, the A. M. A. found grounds for agreement when Congress passed an act which deprived W. W. I veterans with nonservice-connected disabilities of their pension.[11] However, as the New Deal program progressed, the Association became more fearful of too much encroachment by the government into medical affairs.

In the summer of 1934, President Roosevelt appointed the Committee on Economic Security to study social legislation. In addition, as a subcommittee, a Medical Advisory Board was established. The A. M. A. at first did not object to the creation of this Board and, in fact, offered the assistance of its Bureau of Medical Economics. As the consultations between the two progressed, friction slowly developed. On the one hand, the government's representatives

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[11] See House of Delegates, Proceedings (85 Annual Session, June, 1934), p. 32.

advocated expansion of federal health services for certain classes, and on the other the Medical Advisory Board encountered increasing difficulty in discussing health insurance with the A. M. A. On January 4, 1935, the President delivered his message to Congress which contained many proposals recommended by the Committee on Economic Security. He did not, however, suggest a compulsory health insurance plan.

Throughout the 1930's, the A. M. A. was particularly concerned about the possibility of a reawakening of the principles embodied in the defunct Sheppard-Towner Act. In fighting against the passage of a health insurance act, the Association was handicapped by what the times presented. There was increased industrialization, much of the population, due to subsistence incomes, could not afford the costs of medical care, the federal government felt it should accept more social responsibility, and people were cognizant of the dangers inherent in a rampant disease.

In 1938, when an organization in Washington, D. C., attempted to form a group insurance plan, the A. M. A. overstepped its boundary. The Group Health Association(G. H. A.) was formed to provide medical care and hospitalization for employees of the Home Owners' Loan Corporation. The District Medical Society voiced strong opposition to this plan

and sought aid from the A. M. A. to bring pressure to bear on those responsible for its formation. Doctors who joined G. H. A. were either expelled from the local chapter or severely reprimanded, which usually succeeded in making the offending doctor "realize his mistake." A "white list" was distributed to each local hospital and doctor's office naming those organizations and individuals approved by the A. M. A.--the G. H. A. was not on this approval list. Thus doctors of G. H. A. could not obtain consultation with other physicians. To further apply pressure, since G. H. A. had no hospital of its own, the A. M. A. sent a memorandum[12] to each local hospital enlisting their aid in denying staff privileges to G. H. A. doctors. These methods were so effective that an assistant attorney general of the Justice Department, T. W. Arnold, instituted criminal proceedings against the A. M. A. for violation of the restraint-of-trade clause of the Sherman Anti-Trust Act.

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[12]The following was the resolution sent to each hospital in the District: "Resolved, That as a matter of educational policy the Medical Society of the District of Columbia strongly recommends that all hospitals engaged in the teaching and training of residents, interns, and nurses, where possible, follow the recommendations of the American Medical Association regarding the constitution of their entire Medical Staffs, namely, that each appointee be a member of the Medical Society of the District of Columbia and a member of the American Medical Association."

The federal district court of Washington ruled in favor of the A. M. A., stating that the government's charges were too vague. The case then went to the U. S. circuit court of appeals, which reversed the decision of the federal district court. Six weeks later the A. M. A. filed for a writ of certiorari with the Supreme Court. The highest tribunal in America found the A. M. A. guilty and ordered the Association to pay $2,500 in fines. But more important than the money was the humiliating loss of prestige.

On September 1, 1944, the A. M. A. established its office in Washington to enable the Association to maintain close contact with political developments that were national in scope. Numerically speaking, this lobby is one of the smallest with only thirteen in its office. Because of its close contact with a Congressman's personal physician, the A. M. A.'s lobby is the envy of other lobbyists. However, some people are beginning to doubt the credibility of this personal contact.

> Some rather expert observers of the art of lobbying as practiced in Washington assert that the A. M. A. is the only organization in the country that could marshal 140 votes in Congress between sundown Friday night and noon on Monday. Performances of this sort have led some to describe the A. M. A. as the most powerful in the country.[13]

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[13] New York Times, 15 June 1952, 7:6.

Personal contact with the Congressman by his physician is stressed. The A. M. A. lobbyist, upon hearing that a Congressman is planning to vote against the Association's lines, will so inform national headquarters. It, in turn, will notify that Congressman's personal doctor who will write or phone his patient. This technique has met with little success with Senators and Representatives from large cities but it has been more successful with small town and rural members of the House. Apart from direct contact with members of both Chambers of Congress, a committee appointed by the Board of Trustees will review bills of a medical nature. The committee will submit its report to the Board which will announce the A. M. A.'s position on the pending measure. Once their position has been decided, legislators are so informed and pressure is brought to bear on them.

Though small in numbers, the A. M. A.'s lobby has not been lacking in financial resources. In 1950, the A. M. A.'s lobbying allocation was $1,326,078; in 1952, $309,514; and in 1953, it reported expenditures of $106,624.[14] Thus; as the threat of a compulsory health insurance plan declined so did the financial allocation.

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[14] New York Times, 3 May 1953, 34:1.

Both the national and state societies maintain full or part-time public relations men. Their main job is to present the official views of the A. M. A. through advertising on the radio, television, and the press, especially editorial support. Doctors are urged to make speeches before local civic groups to explain various positions of the A. M. A. Usually these speeches are prepared by national headquarters and sent to all member doctors. These speeches range from five to fifteen minutes. Accompanying the speech is a Speaker's Check List, which suggest things to know about the audience, what to do, and what not to do. The medical profession also takes special pride in getting other outside groups to go on record as favoring the A. M. A.'s views.

State medical societies likewise attempt to influence their legislatures. Usually the executive secretary of a state society will occupy a dual role in that he is also the lobbyist whose functions are similar to those of the one in Washington. Physicians are urged to run for political office to insure the proper representation. Prominent local doctors are encouraged to write or personally contact the area's state representative. Patients are asked to do the same. In many states health officials are appointed on the recommendation of the state medical society. In

this way, the medical profession has an indirect hand in the administration of federal health grants.

The A. M. A. also wields a determining influence on matters of a non-medical nature. One example will suffice to illustrate this point. In 1951, the A. M. A. had the Government Printing Office destroy a book, which had been on the market for five years, published by the Federal Security Agency. The thesis of the book, whose title was Common Human Needs - An Interpretation for Staff in Public Assistance Agencies, was that "social workers must never forget that people needing public assistance are sensitive, individual human beings."[15] The president of the A. M. A., Dr. Elmer L. Henderson, took two words that appeared in the book, "socialized state," and apparently warped their meaning that was foreign to the contextual connotation. Dr. Henderson argued the A. M. A.'s case persuasively before a Congressional Committee and consequently the book was removed from publication.

The pressure group tactics mentioned above will be more fully expanded in Chapter Three. From 1945-1960, with five years of intense concentration, 1946-1951, the A. M. A.

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[15]"A. M. A. Forces Ban on Book," Christian Century, LXVIII (23 May 1951), 627. For further information see JAMA, 31 March 1951.

employed every device discussed in this chapter. While the influence of the Association has dwindled somewhat, it is nevertheless powerful enough to defeat most health measures which it feels are contrary to its best interests.

CHAPTER III

CAMPAIGN TACTICS OF THE AMERICAN MEDICAL ASSOCIATION AGAINST GOVERNMENT-SPONSORED HEALTH LEGISLATION, 1945-1960

The political strength of the American Medical Association can be directly related to the status of the doctor in the social structure. The public looks to the doctor for advice and gives great weight to his opinion. This trust is also extended into the political and economic aspects of health. Since 1900, one of the main purposes of organized medicine has been to influence governmental decisions in favor of medicine. Bernard De Voto compared the attitude of the A. M. A. to that of a town which has learned that a dam up the valley has burst and a flood is on the way.

> The dam burst long ago, and year by year the A. M. A. has prepared to meet the flood by saying that it must not get here, that the flood waters are Communistic, that we shall all be lost if they reach the city limits.[1]

In short, the A. M. A. has employed every device to prevent what some people feel is the inevitability of government-sponsored health insurance.

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[1] E. T. Chase, "Politics of Medicine," Harpers, CCXXI (1960), 125.

Medical historians state that health care through a federalized system began thirty years ago. The 1935 Social Security bill provided assistance to states for carrying out their public health programs but no provision was made for general medical care.[2] Then, in 1939, Senator Wagner of New York introduced a national health program bill. By this bill, federal grants would have increased over a ten-year period. This bill, however, like many others, was defeated. After a series of measures, amendments, and alterations the first of a long line of omnibus health proposals, the Wagner-Murray-Dingell bill,[3] was introduced in 1943.

In 1945, and the close of hostilities, the American people began to turn their attention once again to domestic issues. It was at this time that another Wagner bill, based on the 1943 version, was introduced in Congress. The 1945 Wagner bill overshadowed all other forms of health legislation at this time (pending were bills dealing with research, hospital construction, and psy-

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[2]President Roosevelt, in his Message to Congress in 1935, stated "I am not at this time recommending the adoption of so-called 'health insurance,' although groups representing the medical profession are cooperating with the federal government in the further study of the subject and definite progress is being made."

[3]Hereinafter cited as the Wagner bill.

chiatry). The bill itself contained three major parts: (1) communities which lack adequate medical facilities could apply for a federal grant; (2) patients could choose their own doctor and hospital. A point not mentioned is that not all doctors are members of all hospital staffs within a given locale. In this respect one is limited in his choice of doctor and hospital; and (3) doctors may or may not enter this health insurance plan.[4] Special groups, such as clergymen, would have been included only on a voluntary basis.[5]

The program would have been financed through a tax on employees, employer, and the self-employed with the program federally administered. There would have been a 1.5% payroll deduction from both employer and employee—3% from self-employed persons. The payroll deductions for health insurance would have been collected as part of the total social security contribution of 8%, equally divided between employer and employee.[6]

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[4]M. M. Davis, "Health Insurance in Politics," New Republic, CXIII (30 July 1945), 129.

[5]Speech by F. C. Coleman, M. D., before the Educational Programs Conference, Dec. 13, 1964, Chicago, Illinois.

[6]Davis, "Health Insurance," 129.

In charge of this comprehensive system would be the Surgeon General of the Public Health Service and under his auspices there would be an advisory council consisting of professional men and prominent lay citizens.

When the Wagner bill was reintroduced in Congress, in a revised form, the propaganda branch of the A . M. A., the National Physicians' Committee for the Extension of Medical Services (NPCEMS) swung into action. Systematically organized medicine began to downgrade the bill and anybody connected with the program.[7] The pamphlets, brochures, and newspaper advertisements purchased by the NPCEMS attempted to show how our economic system would be changed. They declared our American way of life, whatever that may be, was in danger; that "political medicine," controlled by Washington bureaucrats, would be established; that regimentation of doctors would be the result of the dictatorial powers of the Surgeon General; and that initiative and incentive would be destroyed, thus resulting in an inferior quality of medicine. If there is any one basic, underlying theme of organized medicine's

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[7]The A. M. A. rejected any and all medical bills on the following criteria: freedom of choice, means test, compulsion, and doctor-patient relationship.

opposition to government controlled health, it is that the quality of medicine would deteriorate. The A. M. A. fails to include in its argument how and why the quality would evaporate. The A. M. A. also fails to mention that without government funds research into diseases such as cancer, heart, and respiration would have been sharply curtailed.

The Journal of the American Medical Association was especially bitter toward those doctors who supported the Wagner bill, i.e., Physicians' Forum. Such doctors were branded as heretics, radicals, and communists. The "ism" words, radicalism, extremism, and Nazism, were not foreign to the American public but they were new as a part of the A. M. A.'s campaign against government interference. These words were given a vulgar connotation and anyone associated with them was looked upon as being a traitor to America. The A. M. A. exploited this rising tide of prejudice to the fullest. A basic tenet of their campaign against controlled medicine by the government rested on this pillar of emotionalism.

The United States has had a history of humanitarianism. That is, Americans dislike having to witness some groups of people or nation wantonly suffer.

It is because of this "historical" feeling that a government-sponsored medical program is made a political football. Many people not only lack adequate medical service but they cannot bear the costs of health insurance. This is, it appears, the crux of the bewilderment on the part of the American people. The purpose of the A. M. A., since its conception in 1847, has been to further research and to provide adequate medical care for all people—a humanitarian outlook. Now, the A. M. A. has admitted not all people are adequately taken care of but at the same time denies these people the proper health care by opposing the government plans. Organized medicine has yet to come up with a plan sufficient both vertically and horizontally in character to alleviate medical problems. One may question, not illogically, whether or not organized medicine's purpose is still the same.

Senator Wagner appealed to the A. M. A. to carefully study the bill and all of its ramifications. The senator contended that there was no intention on the part of the government to establish socialized medicine. He further stated that the health provisions of the bill were solely meant to provide a system for paying medical costs in advance and in small amounts.

The A. M. A. rejected the senator's remarks and concurred in the following opinion.

> Compulsory sickness insurance with Federal control is both socialized medicine and state medicine. It is the simple opinion of The Journal of the American Medical Association that the Wagner-Murray-Dingell bill, 1945 version, would also mean the end of freedom for all classes of Americans.[8]

The subsequent defeat of the Wagner bill was only a prelude to the legislative battle against Oscar Ewing's and President Truman's health program of 1950. During the years 1945-50, the A. M. A. was continually engaged in strategy meetings, molding public opinion to its point of view, and securing the necessary finances. Obviously, to conduct a campaign of this magnitude required a considerable amount of money. Upon hearing that President Truman planned to push proposals for federal compulsory health insurance, the A. M. A.'s House of Delegates, meeting in secret session at its winter conclave in St. Louis (1948), voted to spend $3,500,000 in an effort to combat medical legislation. This meant that each of the 140,000 members would be assessed $25.[9] It was not

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[8] M. M. Davis, "Senator Wagner and the A. M. A.," Survey Graphic, XXXIV (Aug. 1945), 342. For further information see The Journal of the American Medical Association, June 2, 1945, and Survey Graphic, June, 1945.

[9] "A. M. A. War Chest," Newsweek, XXXII (13 Dec. 1948), 46.

mandatory to pay this fee. According to the A. M. A., the money would be used in an honest effort to educate the people to the fact that the American System is the best way to secure quality medicine. Approximately 20% of the A. M. A.'s doctors refused to pay the money. These maverick physicians were not necessarily for government-sponsored medicine. Their attitude was based on the thesis that the assessment would add fuel to the argument of the advocates of socialized medicine that the motives of the medical profession were selfish and economic.[10] The $25 assessment by the A. M. A. hierarchy on its members shocked the American people. No one realized the medical profession would go that far. The heat of the campaign, its pace, and sometimes surprising statements caused many people to wonder about the true position of the doctor turned politician.

The policy-making branch of the A. M. A., the House of Delegates, spurned a proposal in 1948 by the Blue Cross-Blue Shield Commissions for a health program.

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[10]H. Aaron, "Doctor in Politics," Consumer Reports, XV (Feb. 1950), 76.

The theme of this nonprofit national health insurance company was to issue policies covering hospital and medical bills on a nationwide scale. This plan would have allowed big business to sign one contract covering all employees regardless of where they worked. The plan would have given more people better medical care and could have conceivably lessened agitation for compulsory health insurance.[11] Once again the A. M. A. said no. There was too much interference with doctors on the part of laymen and it was too much akin to socialized medicine. If the A. M. A. was to present a united front, it would have to oppose any and all medical measures whether they were good, bad, or otherwise.[12] Any breach of continuity could do irreparable damage to their campaign. At this point it is necessary to present a cursory reivew of socialized medicine in Great Britian.[13] The A. M. A., more then than later,

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[11]"Alarming Symptoms," Time, LII (13 Dec. 1948), 88.

[12]However, the A. M. A. has shifted its position somewhat. See Eldercare in Appendix B.

[13]Much of my information is derived from Harry Eckstein, Pressure Group Politics--The Case of the British Medical Society (Stanford: Stanford University Press, 1960), pp. 40-72 and 92-112. Hereinafter cited as Eckstein, B. M. A.

made continuous reference to the British Medical Association (B. M. A.) with its attendant deficiencies and dissatisfied physicians.

The doctors of Britian, under the National Health Act of July 5, 1948, are classified into four categories—(1) general practitioners, (2) hospital doctors, consultants, and specialists, (3) full-time clinical teachers, and (4) medical officers of health and their associates in the local health units. In the forefront are the general practitioners. Each doctor has a list of persons in his area who have joined the health service and have chosen him as their physician. The government pays the doctor so much for each person per year. The maximum number of patients a practitioner is allowed to serve is 4,000. In the beginning, persons under this system received free medicine. When 1952 dawned they were told a small fee would be assessed; still, it was cheaper than our fee-for-service system. The people have the privilege of changing doctors provided the doctor they choose did not have over the established number of people allowed on his list. A special category was established for those hospitals that were to serve as educational institutions. Each hospital so designated would have its board of

governors, which is appointed by the university concerned, the hospital staff, and the regional board. It was felt that this type of system could insure a measure of academic freedom in medical education and it would also minimize the amount of political influence.

Only recently has the B. M. A. taken an active part in politics as compared to its counterpart, the A. M. A. Like the American Medical Association, the British Medical Association is regarded as the doctor's public relations office, trade union, his spokesmen before the public, and his bargaining agent with the government. Despite public opinion, the B. M. A. is engaged in constant cooperation with the Ministry of Health. The B. M. A. attempts to guide public opinion to its point of view but makes no real effort to force the issue. Public opinion is not considered a potent factor in its activities. The absence of any real major disagreement on medical policies in Britain is explained, in part, by the fact that the B. M. A. and political issues are not very newsworthy.

The B. M. A. makes a concerted effort not to alienate any of the political parties by not converting the society's issues into political issues. For this

reason the medical profession in Britain avoids identifying itself with a party. The A. M. A. likewise holds this position—that is, nonaffiliation with either party. But if you accept the premise that big business, and the A. M. A. is big business, leans toward a laissez faire government, then it is readily seen that the A. M. A. would tend to favor one party over the other.[14]

The B. M. A. employs a Parliamentary agent to review all pending legislation and notify it of anything relevant. However, this agent does not enjoy the power and the influence that the A. M. A.'s lobbyist does. The relationship between the B. M. A. and the Ministry of Health comprises medical politics in Britain. Generally speaking, this relationship has been good. The Ministry and the Association are encouraged to establish close relations and to seek agreement whenever possible.

> In this search for agreement, however, it is the Ministry which acts under the greatest compulsion to make concessions, for the B. M. A. can realize its ambitions to become a truly monolithic structure only by being a highly successful bargaining agent for the profession.[15]

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[14]A Chicago law firm, in 1950, at the direction of the A. M. A., prepared a memorandum stating the relationship between the doctor and political affairs. The main tenet stated that any doctor actively supporting a political candidate must do so as an individual. The A. M. A. could not endorse a candidate, contribute any funds to a candidacy, or sign an advertisement endorsing him.

[15]Eckstein, B. M. A., 72.

Of all the nations that set up national health services under the auspices of the government, Britain is the one most closely related to us. An attempt should be made to study its system carefully and with open minds. The medical system in England was brought about by conditions that were non-existant in the United States and was meant to serve that country's society, not ours.

> That socialized functions can exist in a democracy without in any way threatening that democracy politically is something which conservative medical politicians in the U. S. seem to be incapable of comprehending. But in the U. S. it will be in the end the whole people, not the doctors alone, who will direct the course of events.[16]

Thus, in referring to the ills of medicine in Britain, the A. M. A. has not adequately informed the American people. The foremost thought to bear in mind is that an institution in one country may not necessarily be applicable to another country.

The A. M. A.'s tactics of opposition to the government were more extensive from 1947-50 than in any other comparable years. Prior to 1939, little more than vocal opposition by medical spokesmen was required to defeat government health proposals. From 1939, the

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[16]Eckstein, B. M. A., 118.

A. M. A. increasingly saw the need to employ other methods and to create new financial reservoirs. In 1947, the A. M. A. spent $345,000 to combat government controlled health insurance; in 1948 it spent $353,000 for the same purpose; and in 1949 the medical profession spent $3,500,000 to preserve the American system of free enterprise, more than a two-million dollar increase in campaign funds.[17] The Democratic victories in Congress, the publishing of the Ewing report, and the fact that Britain had a national health service all gave impetus to serious discussions concerning the adoption of a national health program.

To aid its campaign the public relations firm of Whitaker and Baxter was hired at a salary of $100,000. This firm solicited endorsement from the leaders of one-hundred state organizations, more than two-hundred newspapers pledged their support, and speeches were made before more than nine thousand physicians. They persuaded doctors, dentists, insurance men, and druggists to make speeches before innumerable "thought leaders." These "thought leaders" consisted of the presidents of 400 civic clubs,

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[17] "A. M. A. Rides Again," Survey, LXXXV (Ja. 1949), 56.

280 officers of veterans organizations, 500 women's club officers, 200 insurance executives, and other public officials.[18]

The $508,000 that was spent during the first six months of 1948 went, in part, to the purchase of 25,000,000 pamphlets and 10,000,000 newspaper advertisements. However, not all of the campaign tactics were successful in terms of being tolerated by the American people, i. e., in 1948, the propaganda branch of the A. M. A. offerred a $3,000 prize for the best published anti-national health insurance cartoon. Despite the caustic remarks, the money was awarded.

In December of 1949, at the Third Annual Clinical Session, a doctor was quoted as saying, "The A. M. A. won't leave a stone unturned in its efforts to defeat the government's health program."[19] To further aid them in this endeavor, insurance companies agreed to distribute 1.5 million anti-health brochures. The two lobbies, A. M. A. and Insurance, purchased full-page ads in

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[18]Williams, "Government by Whitaker and Baxter, II," The Nation, (21 April 1951), 366.

[19]"Propaganda Clinic," New Republic, CXXI (12 Dec. 1949), 9.

12,000 daily newspapers. Those insurance companies, whose main purpose was to promote A. M. A. controlled voluntary health insurance programs, openly aiding the medical profession were: (1) National Association of Insurance Agents, which was the largest one with 20,000 independent agencies throughout the country; (2) American Life Convention, which was composed of 227 of the largest life insurance companies; (3) Provident Mutual Life of Philadelphia; (4) Bankers Life and Casualty Company; (5) Bankers National Life; and (6) the Combined Insurance Company of America.[20] The following statement by Senator McClellan of Arkansas did little to allay the fears of the A. M. A. The Senator stated, "If the compulsory program is enacted into law we can expect within five years that the cost of operating the Federal government will be at least $60,000,000,000 annually."[21] Of that, $15,000,000,000 would have been spent on the Truman national health program.

The public relations team of Whitaker and Baxter formulated the following theme that would permeate

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[20] Ibid, 9.

[21] "Doctors Gird for Battle," Newsweek, XXXIII (20 June 1949), 50.

every pamphlet, brochure, and newspaper ad: "Down with compulsory health insurance; compulsory health insurance is socialism; socialized medicine is state socialism; state socialism is eternal damnation."[22] The medical profession followed this up with the picayune cry that the "American way is the voluntary way." Another essential part of the Association's argument is that it was afraid of lay interference in medical problems. The doctor knows better than a politician with no background in medicine—this seems to have been the most persuasive argument. Regardless of cost or sacrifice people want only the best possible care for their family.

From all the proposals and counter proposals suggested, it boils down to the fact that there are three ways to provide health insurance for people: (1) the government, which has been and will be discussed; (2) the A. M. A., which has supported one type of plan—the fee-for-service; and (3) private associations of which one example will suffice—the 1947 Health Insurance Plan (H. I. P.) of New York City.

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[22] J. H. Means, "Doctors' Lobby," Atlantic Monthly, CLXXXVI (Oct. 1950), 57.

For a fixed annual premium of $34 (it may be somewhat higher now) for one person this plan will provide for complete medical care at his own home, the hospital, or the doctor's office. This premium of $34 increases proportionately for each member of the family until a ceiling of $103.68 is reached. Beyond this, no additional amount is charged regardless of the family size. For individuals with annual incomes of $5,000 or families with $6,500 annual income or more the premiums are 50% higher.[23] Those belonging to H. I. P. likewise have to join Blue Cross. Thus, the combination of the two plans give complete medical coverage and nearly complete hospital coverage. This system was originally intended for city employees only but was soon open to everybody. The H. I. P.'s success is proof that a private health insurance program is possible.

The A. M. A. fully realized that the 1949 campaign was only a respite of temporary proportions. With this in mind, the medical profession planned its 1950 campaign to end for all time the threat of national health insurance. Much of the 1950 plans were a continuation

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[23] Ibid, 59.

of those employed in 1949. An intense two-week campaign was planned to coincide with Congressional elections. The A. M. A. was going to "crystallize public opinion against socialized medicine" through the use of 11,000 newspapers and through the use of 30 national magazines, which were to run full-page ads. Also, 300 radio stations were to make periodic announcements.[24] Doctors were told they would have to personally inform their patients of the A. M. A.'s point of view.[25] They were also told the number of hours they were expected to work to insure defeat of the pending legislation.

Once again, in 1950, the A. M. A. assessed its members $25, which was to remain the permanent yearly dues. Among physicians, there were three reactions to the assessment: (1) some doctors refused to pay and lost their membership, (2) some paid to avoid personal problems, and (3) some paid in hopes of fighting the A. M. A. from within.[26]

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[24]"Campaign to Defeat Compulsory Health Insurance," Nation, CLXXI (8 July 1950), 21. For further information see New York Post, 23 Oct. 1950, 4:1; Boston Post, 11 Oct. 1950, 33-40; and New York Times, 26 Nov. 1950, 9:2.

[25]See Appendix F.

[26]New York Times, 17 Jan. 1951, 26:6.

The sponsor of Federal health legislation, John Dingell of Michigan, described the 1950 campaign as an attempt,

> .... to doctor, drug, and slug the American people into believing the crude big lie that sickness is health; that the President's plan for National Health Insurance is socialism; that insurance (compulsory) is socialism and communism.[27]

To further aid their campaign, the A. M. A. solicited $19,000,000 from other sources—railroads and private power companies, Blue Cross and Blue Shield, wholesale and retail drug companies, 24 of the largest insurance companies (p. 46), and the National Retail Dry Goods Association. It will be noted that some of these agencies are not even remotely connected with medicine. The question may be raised concerning their support of the medical profession. The indication is that they, too, like the A. M. A., are big business and a successful campaign against more government regulation would also be a victory for them.

The campaign of 1949, and especially of 1950, has been dubbed by some as "Practitioners Pip." And

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[27] J. Begemen, "Crude Big Lie," New Republic, CXXIII (2 Oct. 1950), 15. Brackets mine.

it does seem that doctors had overstepped their boundary.

> We know of one physician who was thrown so far off his stride that he wouldn't treat a case of German Measles until he was assured it was Western zone.[28]

There was another more negative effect of the A. M. A.'s campaign efforts. If the more than $20,000,000 had not been spent on advertising, it could have otherwise purchased all of the following:[29]

1. One year's medical cost for 160,000 families with $3,000 annual income.

2. Four-year tuition to medical school for 9,000 students who could have cared for six million patients.

3. Train 5,500 heart specialists to combat the 600,000 annual death toll due to heart disease.

4. Provide 100 beds in mental and tuberculosis hospitals.

5. Provide 11 fully equipped health centers.

6. Furnish two-year fellowships for 2,000 scientists for advanced medical research.

The fact that all of these could have been available is not very becoming of the disciples of Hypocrates. In the end it was the people who lost. The original

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[28]"Campaign to Defeat Compulsory National Health Insurance," Nation, CLXXI (8 July 1950), 21.

[29]J. Begemen, "Crude Big Lie," New Republic, CXXIII (2 Oct. 1950), 16.

purpose of the A. M. A. was to provide adequate medical care for all persons. In view of the campaigns conducted it would appear that the A. M. A. has changed. A cursory review would seem to indicate its goal is the same but if the medical profession was really concerned about the health of people, why was not the campaign money spent on more constructive endeavors such as those mentioned above? All this campaigning may eventually be a disadvantage. It has driven home and brought to the attention of the American people the increasing need for adequate health insurance for most individuals.

Oscar Ewing, head of the Federal Security Commission and the avowed enemy of the A. M. A., formulated a plan of his own. Under this, Ewing wanted to levy a 4% payroll tax, take several billion dollars from general revenues, and cover hospital and medical care for 85% of the population. Doctors would be free to join the plan and could decide whether they wanted to be paid by fee-for-service, a per capita rate, or a salary. The A. M. A. and its allies defeated the plan so convincingly it has yet to be revived. During the 81st Congress, other medical bills, as a result of the A. M. A.'s exhaustive and intensive campaign, were likewise defeated.

First and foremost, they were able to defeat the general medical care bills of which there were seven, i. e., Ewing's Plan. Secondly, they defeated a bill that provided a cabinet status for the Federal Security Commission. The School Health Services Bill was rejected on the grounds that it did not provide a means test for parents. Specifically, the bill would have widened medical examinations for school children and provided care for any defects found. A fourth bill to be defeated was Federal Aid to Rural Health Plans. Another bill not acceptable to the A. M. A. was Federal Aid to Local Public Health Units. This would have broadened public health services by giving grants for work and research in chronic diseases. The Disability Insurance Bill

> would create unfortunate relationships between physicians and patients... and project the Federal Government into an area of welfare work which should remain a state responsibility.[30]

Federal Aid for Medical Schools, it was feared, would lead to Federal control of medical education and hence, it was also defeated. Finally, the Omnibus Medical Research Bill was rejected.

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[30]"A. M. A. Hobby Buys $1,110,000 Worth of Ads," Consumer Reports, XV (Oct. 1950), 454.

Much has been said concerning the A. M. A.'s tactics on a national level. Member doctors were also active on the local scene in organizing Healing Arts Committees. The effectiveness of these committees in other elections had already been demonstrated. Some people assert that these Healing Arts Committees were directly responsible for the defeat of Congressional candidates who favored national health insurance.[31] The 1949 26th Pennsylvania Congressional District election will suffice as an example.[32] The Healing Arts Committees in that District mailed more than 190,000 letters, conducted 120,000 Personal telephone calls, purchased radio time to urge election of their candidate, and had twelve advertisements placed in each of the District's newspapers. The efforts of the profession were well rewarded. Election results showed that the total turnout approached the 1948 presidential election and

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[31]Claude Pepper of Florida and Frank Graham of North Carolina, who were both U. S. Senators, are prime examples. See San Francisco Chronicle, 27 June 1950, p. 2; New York Post, 24 Oct. 1950, 35:1-2; and New York Times, 26 Nov. 1950, 9:2.

[32]"The American Medical Association: Power, Purpose, and Politics in Organized Medicine," Yale Law Journal, LXIII (May 1954), 1016.

20,000 Democrats switched their votes.

The year 1951 was similar to 1950 insofar as medical legislation was concerned. Bills such as care for those rejected by the military forces for physical or mental reasons, needs in the fields of nursing, dental, and medical education, and more local health units were all defeated by the A. M. A. Section 23 of the Senate's Universal Training Bill stated that the federal government would appoint a civilian agency to rehabilitate men rejected by the armed forces. There is a degree of politics involved but basically this was a good, moral, and judicious scheme. The A. M. A.'s attitude was,

> Here, in the guise of a national defense measure, is a new medical proposal that surpasses, in the extent to which it nationalizes medicine, even the compulsory health insurance bills....[33]

One issue that received more emphasis in 1951-2 than at any other previous time was Federal aid to medical schools. The A. M. A.'s position (p. 53) was challenged in Congressional hearings by individual doctors, especially deans of medical schools. These deans claimed

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[33]G. C. Stoney, "Doctors in Washington," Survey, LXXXVII (May 1951), 227.

they needed $40,000,000 annually over and beyond their regular income to support medical schools. Also, more than $300,000 was needed for construction purposes. As an alternative to federal aid to medical schools, the A. M. A. offered a counter proposal which was based on a voluntary plan through private fund raising. The A. M. A.'s treasury donated $500,000 and asked each doctor to contribute $100. It is difficult to see how the medical profession could have, through this system, raised $40,000,000 annually.

It was obvious to many people that the picture on national health insurance was not altogether too clear. There was a definite need for an objective survey of medicine in the United States. For these and other reasons, President Truman appointed a Commission on the Health Needs of the Nation to accomplish this task. Appointed to serve on this Commission were prominent doctors, farmers, laborers, consumers, and businessmen. Its purpose was threefold: (1) recommend ways for improving the distribution of health facilities, (2) study the health needs of the country, and (3) study the availability of medical care. The establishment of this Commission brought on an expected wave of

criticism from the A. M. A. The medical profession, so powerful was its position in politics, had one of the members removed before the Commission ever met. The opposition by the A. M. A. to this study may lie, in part, in the fact that the Association knew health care was inadequate to meet the needs of all people. Perhaps they also felt the Commission's report would be too objective.

Dr. Gunnar Gunderson, in tendering his resignation from the Commission, stated,

> I believe I am correct in assuming that the commission is designed, both in its majority membership and in its objectives, as an instrument of practical politics to relieve President Truman from an embarrassing position as an unsuccessful advocate of compulsory health insurance.[34]

If the President had as one of his objectives in establishing the Commission on Health Needs a reawakening of public interest, it would appear he was successful. The following dialogue will exemplify the heated verbal barbs that were exchanged between the A. M. A. and the President.[35]

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[34] New York Times, 31 Dec. 1951, 15:6.

[35] "Mr. Truman vs. the A. M. A.," Nation, CLXXIV (12 Jan. 1952), 24.

It will also show why public interest was aroused.

> A. M. A.: The action of Truman is "a brazen misuse of defense-emergency funds for a program of political propaganda designed to influence legislation and the outcome of the 1952 elections... There is no health emergency in this country to require such an investigation, since the health of the American People never has been better."
>
> Truman: "What I want is a good workable plan that will enable all Americans to pay for the medical care that they need. And I will say here and now that if the people who have been blocking health insurance for five years will come up with a better proposal—or even with one that is almost as good—I will go along with them."
>
> A. M. A.: "A better program is already available and is functioning admirably—the American medical system, which has made this the healthiest great nation in the world."

If the present system is "functioning admirably" then why was, and still is, the government attempting to expand health insurance? If the present system "made this the healthiest great nation in the world" how did the A. M. A. explain the fact that both maternal and infant-mortality rates were lower in socialized Britain than in the United States?

At the conclusion of its study, the Committee on the Nation's Health urged adoption of Truman's

health plan and made the following recommendations:[36] (1) funds to underwrite the cost of medical schools, (2) aid to states where areas were lacking in public health units, and (3) national health insurance as part of the Federal social security program. The government proposed budget for federal aid to medical schools, assuming legislation had been passed, plus scholarships amounted to $25,000,000 for the 1951 fiscal year. Also, $5,000,000 had been set aside to aid local health units. The state and local governments were to have received more than one-half of the Federal government's expenditures for health purposes—$350,000,000.[37] This money would have aided hospital construction, child and maternal health, general health services, and the control of enumerated diseases. However, then as now, the Federal government directly aids research and hospital activities of the Public Health Service. In research, for example, it was the Federal government that gave impetus to the production of radioactive isotopes to be used in the diagnosis and

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[36] New York Times, 7 Jan. 1951, 28:1.

[37] New York Times, 16 Jan. 1951, 23:4-6.

treatment of thyroid disorders, heart disease, and cancer. But the government had to spend billions in creating atomic energy before this was possible. The government further supports research in one-fourth of the medical schools through the Defense Department, Atomic Energy Commission, and, as mentioned, the Public Health Service.[38]

The Democratic Platform[39] for 1952, as far as medicine was concerned, went on record as favoring federal aid to medical schools and federal aid to hospital construction. It was pledged to a "resolute attack on the heavy financial hazard of serious illness." The Democrats promised to work with the medical profession in combating specific diseases--mental illness, cancer, and heart ailments. Again, as in previous elections, the A. M. A. as an organization took no sides. However, approximately a month before the election a National Professional Committee for Eisenhower and Nixon began mailing letters urging medical societies to support the Republican ticket.[40]

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[38] New York Times, 20 Nov. 1952, 1:4.

[39] New York Times, 24 July 1952, 17:5.

[40] For further information see New York Times, 28 Oct. 1952, 25:4-8.

Of the Republican victory, Truman said it was not a mandate to end the fight for medical programs sponsored by the government.

> The health of the American people is one of our basic national resources. It is as important to the welfare of our country as our land, our water, and our minerals. It is just as logical, just as important, for us to be concerned about health.[41]

The election of Dwight Eisenhower to the Presidency in 1952 ushered in a new era of medical-political relations. For a period of approximately seven years the relationship between the medical profession and the White House was, on the whole, good. Public appeal for the Wagner type of legislation waxed and waned in the 1950's and national health insurance for the general population became a dead legislative issue. Proposals for Federal programs for health care for the aged[42] did, however, attract growing Congressional attention.

During the 1950's, three things were directly responsible for the less vehement situation regarding medicine and politics. One was the devasting defeat of government-sponsored health legislation by the A. M. A. It almost became political suicide

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[41] New York Times, 20 Nov. 1952, 1:4.

[42] Aged is usually referred to as those individuals over 65.

to oppose the Association. Second, there was a trend toward a more liberal attitude by many doctors. This trend was aided by a growing realization that in light of the recent campaigns by the A. M. A. public opinion might be a source of agitation for urging the government to continue its fight. A Georgetown University medical professor, Dr. Maris Mollari, advised the A. M. A. to recognize the need for universal medical care before "it is shoved down our throats" by politicians.[43] He cited the new trends in medicine that had made the cost too enormous for the public to bear as the reason for his advice. One further example of this liberal tendency is given by a past president of the A. M. A., Dr. Edward J. McCormick. He urged the adoption of an average fee schedule based on an area's ability to pay.[44] In his opinion, it was time doctors refrained from charging fees that were based on their patient's income. Dr. McCormick's system would have provided a better approach to the writing of major hospital and medical expense insurance. Also, it would have facilitated the

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[43] New York Times, 13 Sept. 1954, 20:5.

[44] New York Times, 22 June 1954, 19:3.

handling of benefits offered in definite geographic areas by insurance companies. Finally, and perhaps the most important, was President Eisenhower's attitude toward medicine. The Republican Platform was unequivocally opposed to national health insurance. In his State of the Union address in January, 1954, the President left no doubt as to his position on the matter. In that State of the Union address, Mr. Eisenhower stated,

> I am flatly opposed to the socialization of medicine. The great need for hospital and medical services can best be met by the initiative of private plans.[45]

Thus, he rejected Truman's national health program.

On January 18, 1954, the President submitted to Congress a special health program. In this health message he set forth a five-point plan that would expand aid to more people and yet avoid socialization of medicine. The first step would have been the creation of a $25,000,000 fund to set up restricted government re-insurance service. Under this, each participating plan, i. e., Blue Cross,

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[45] New York Times, 8 Jan. 1954, 10:7.

> would pay into a Federal insurance agency a certain proportion of the premium collected from its members. The government would then guarantee to meet any liability exceeding a certain maximum....[46]

Second, he proposed increased aid to states and local areas through such endeavors as construction of non-profit clinics, nursing, and rest homes. Third, the President proposed an extended program of rehabilitation for the disabled. Of the more than 2,000,000 disabled in the United States in 1954, with 25,000 expected to be added each year, only 60,000 were restored to the point of being able to lead a normal life.[47] Fourth, he suggested increased support for the research function of the Public Health Service. Fifth, and last, Mr. Eisenhower would have made it easier to acquire federal grants for health. "The health of our people is the very essence of our vitality, our strength, and our progress as a nation."[48] In this, he was close to Truman's views (p. 61).

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[46] New York Times, 11 Jan. 1954, 10:3.

[47] New York Times, 19 Jan. 1954, 24:1.

[48] New York Times, 19 Jan. 1954, 1:8.

The A. M. A. did not take an official stand on the program but one member, former president Dr. A. J. McCormick, was fearful of the $25,000,000 fund. Though the sum was small, there was the possibility of its increasing, thus causing some private insurance companies to go out of business.

To continue with the President's health report, Mr. Eisenhower saw two main problems: (1) distribution of medical facilities and (2) costs of medical care. In 1953, there were 159 practicing physicians for every 100,000 persons in the northwest section of the United States; 126 in the west; 116 in the south central section; and 92 in the south. Also, in 1953, there were only 4-5 hospital beds available for every 1,000 in some states and 10-11 for every 1,000 in other states. In view of this unbalanced situation, a goal of Eisenhower was to make good health available to all. Thus, the President summed up the theme of his health program when he stated,

> The means for achieving good health should be accessible to all. A person's occupation, location, age, race, creed, or financial status should not bar him from enjoying this access.[49]

Perhaps one of the stronger attacks during this "era of good feeling" was a report by the Yale Law Journal, May, 1954. This two-year study concluded that the A. M. A. exercised dictatorial control over its members.

> No other voluntary association commands such power within its area of interest as does the A. M. A. The association holds a position of authority over the doctor, wields a determining voice in medical education, controls the conditions of practice and occupies a unique position of influence in shaping Government health policies.[50]

The A. M. A. refuted the report on the grounds of inaccurate facts.

In December of 1954, a portion of Eisenhower's program was carried out when the government granted $10,275,533 to medical institutes that have conducted 972 medical projects. Research would take place in such areas as heart disease, cancer, mental ailments, arthritis, multiple sclerosis, cerebral palsy, epilepsy, influenza, the common cold, gout, diabetes, and disease of the liver, teeth, and mouth.[51] This grant and the subsequent

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[49] New York Times, 19 Jan. 1954, 24:1.

[50] New York Times, 3 Aug. 1954, 21:8.

[51] New York Times, 24 Dec. 1954, 10:8.

success in many of these fields does much to discredit the A. M. A.'s claim that the quality of medicine would decline if the government interfered.

Despite the lack of any apparent cleavage from the time of Eisenhower's first administration to near the end of his last, the A. M. A. continued to be a determining influence on the government's health program. The association's lobbyists in Washington were in constant touch with national headquarters to report any new trends, attitudes, and relevant legislation. Any show of relaxing its guard on the part of the A. M. A. was purely superficial.

In 1957, the Aime Forand bill was introduced. This bill is generally known as the forerunner of the federally financed health care for the elderly under Social Security. The Forand bill would have provided hospital, surgical, and nursing home benefits under the auspices of the Social Security System. However, this bill was not reported out of the House Ways and Means Committee. During 1959-60, this committee directed the Secretary of Health, Education, and Welfare to conduct a study to seek alternative ways of providing adequate health care for the aged. The report, in its final

analysis, favored federal grants to the states to aid in financing medical benefits for those over 65. Another report was also submitted by a Senate Subcommittee of the Committee on Labor and Public Welfare. This report recommended that the Social Security system be expanded to include health benefits for all persons eligible for Old Age and Survivors benefits. In 1960, the House Ways and Means Committee, after closed sessions in which the above proposals plus various amendments were taken into consideration, reported out a bill which passed the house 380-23.[52] This subsequently became known as the Kerr-Mills bill. The Senate Finance Committee, in hearings on the measure, rejected an amendment that would have included Social Security payroll tax financing. Likewise, the Committee rejected amendments by the then Senator Kennedy and Senators Anderson and Javits. The Senate then passed the Kerr-Mills bill and it continues to function to the present time. The A. M. A. offered little resistence to this bill and today actively supports Kerr-Mills. The Act provided increased federal aid for the health care programs for those individuals on Old Age assistance. It also created a new program of Medical Assistance for the Aged. In short, federal aid was granted to state health programs already in existance.

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[52]Speech by Dr. F. C. Coleman, op. cit.

The years 1961-65 have not been covered in this study. Names such as King-Anderson, Medicare, and Eldercare, along with their provisions, may be found in the Appendix. For approximately thirty years the A. M. A. has successfully fought off attempts by the government to sponsor compulsory health insurance. The success to which the medical profession is accustomed may finally be terminated by the present Democratic Congress.

CONCLUSION

No one will deny the right of doctors in this country to lobby, to organize, and to form political action groups. The social and political system of the United States permits and encourages pressure groups. If the A. M. A. ceases to be purely a medical society and seeks to become a part of the political power structure, should it expect the traditional respect people have given to doctors? It is debatable whether or not the Association should continue to reap the benefits which have resulted from the physicians' high position in the social structure.

This paper has attempted to show how the A. M. A. has had an impact on American politics, particularly as it relates to legislation. Many people feel that the A. M. A. lobby is one of the most powerful in Washington. Others would argue that it is powerful, yes, but not the most potent of all lobbyists. The proponents of the latter claim that the doctors are so absorbed in the natural sciences and their own work that they are devoid of knowledge in other fields. They also argue that doctors who do discuss political matters are consistently A. M. A. propaganda media.

In the 1949-1950 campaign, the A. M. A. resorted to all facets of communication media. The Association employ-

ed every legal device to bring pressure to bear on legislators. But the public will never be aware of the compromises, promises, and concessions that took place behind the scenes. The tactics implemented by the A. M. A. in their struggle against compulsory health insurance could lead one to feel that the medical profession had ulterior motives.

If socialized medicine would benefit the country as a whole, should organized medicine gracefully bow out of the picture? If, on the other hand, the A. M. A. feels that the existing situation is sufficient to meet the needs of people, should it continue to resist efforts by the government to subsidize medicine?

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A P P E N D I X

APPENDIX A

Medical Schools[1]	Students	Graduates
University of Pennsylvania	411	163
Transylvania University	205	64
Harvard		
College of Physicians and Surgeons, New York	194	51
University of City of New York	410	123
Ohio Medical School	170	53
Med. Institution of Geneva College	158	43
Med. Dept. of Willoughby College	160	
Albany Med. College	100	32
University of Louisville	349	75
Western Reserve College	216	
Franklin Med. College	17	5
Pennsylvania Med. College	95	33
Jefferson Med. College	492	177
Rush Med. College	70	16
University of Maryland		
Med. College of Georgia	106	33
Med. Dept. Hamp. Sidney College	75	17
Med. College, State of S. Carolina	204	74
Med. Dept. Univ. of Missouri	102	28

[1]"American Journal of the Medical Sciences," Vol. XXIX (Jan. 1848), p. 316.

Medical Schools	Students	Graduates
Indiana Med. College	104	19
Berkshire Med. Institution		42
Med. College of Louisiana	166	27
Med. School of Maine		
Vermont Med. College	96	
Yale Med. College		28
Castleton Med. College	131	42
Memphis Med. College	55	
New Hampshire Med. School		
Buffalo Med. College	67	17
Washington Med. College		
Med. Dept. Columbia College		
Med. Dept. St. Louis University		13
Med. Dept. of Illinois College	39	13

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COMPARISON OF MAJOR PROVISIONS OF THE MEDICAL ASSISTANCE FOR THE AGED LAW WITH THE AMENDMENTS TO IT PROPOSED BY THE ELDERCARE ACT OF 1965

Existing Law	H.R. 3727, (Congressman Herlong) H.R. 3728, (Congressman Curtis) and others

A. BRIEF SUMMARY

Permits States to include in their plans under Title I a program of medical assistance for the aged (MAA); that is, to provide medical vendor payments (payments directly to the suppliers of medical services) for aged persons who are not old-age assistance recipients, but whose income and resources are insufficient to meet the costs of necessary medical services. The State plan for medical assistance for the aged may specify medical services of broad scope and duration provided that both institutional (hospitals, etc.) and non-institutional (outpatient clinics, etc.) services are included.

There is no dollar ceiling, the overall amount of Federal participation is governed by the extent of the State programs. The Federal share varies from 50 percent (for States with per capita income equal to or above the national average) up to 80 percent for lower per capita income States.

Adds a new section to Title I which would authorize a State, at its option, to provide MAA in the form of premium payments for guaranteed renewable private health insurance. Such coverage would have to be made available to all aged residents in the State. As to MAA recipients, there would be State and Federal participation in the full cost of the payment. As to individuals above the MAA maximum income limit, there would be part payment by the individual, in such proportions (based on his income) as the State agency may determine, up to such higher level as the State agency may consider appropriate. Above this level all the premiums would be paid by the individual. Certification of income under oath shall be accepted as conclusive for eligibility purposes. Increases Federal participation in State MAA expenditures by 5% as to that portion in the form of health insurance coverage under the new section.

Modifies MAA income and resources test to one of income alone. Excepts from prohibition against enrollment fees and premium charges the assistance provided under the health insurance coverage above. Provides that a statement of income under oath shall be accepted by State agency as conclusive for eligibility purposes.

Existing Law	H.R. 3727, (Congressman Herlong) H.R. 3728, (Congressman Curtis) and others

B. ELIGIBILITY FOR ASSISTANCE

To be eligible an individual --

(1) must have attained age 65;
(2) must not be a recipient of old-age assistance;
(3) must have income and resources, as determined by the State, insufficient to meet all of the cost of the medical services outlined below. The State plan must provide reasonable standards, consistent with the objectives of the program, for determining eligibility and the extent of assistance.

(1) same as existing law;
(2) same as existing law;
(3) modified so that assistance would be provided in behalf of individuals whose income (rather than income and resources) is insufficient to meet the cost of necessary medical services.

C. SCOPE OF BENEFITS

The State plan for medical assistance for the aged may specify medical services of any scope and duration, provided that both institutional and noninstitutional services are included. Federal participation is restricted to vendor medical payments: i.e., payments made by the States directly to the doctor, hospital, etc., providing medical services on behalf of the recipient.

The Federal Government shares in the expense of providing the following kinds of medical services:
(1) Inpatient hospital services;
(2) Skilled nursing home services;
(3) Physicians' services;
(4) Outpatient hospital (or clinic services);
(5) Home health care services;
(6) Private duty nursing services;
(7) Physical therapy and related services;
(8) Dental services;
(9) Laboratory and X-ray services;
(10) Prescribed drugs, eyeglasses, dentures, and prosthetic devices;
(11) Diagnostic, screening, and preventive services; and
(12) Any other medical care or remedial care recognized under State law.

Same as existing law.

Existing Law	H.R. 3727, (Congressman Herlong) H.R. 3728, (Congressman Curtis) and others
The Federal Government does not share in the expense of providing medical services to inmates of public institutions (other than medical institutions), to patients in mental or tuberculosis institutions or to patients in medical institutions as a result of a diagnosis of tuberculosis or psychosis after 42 days of care.	Removes exclusion from Federal matching as to aged individuals who are patients in institutions for tuberculosis or mental diseases, or who have been diagnosed as having tuberculosis or psychosis and, as a result, are patients in a medical institution.

D. MATCHING FORMULA

Federal share

Federal payments reimburse the States for a portion of their expenditures under approved plans for medical assistance for the aged according to an equalization formula which ranges from 50 to 80 percent depending upon the per capita income of the States as related to the national per capita income. States at or above national average get a 50% Federal share.	Same as existing law except that as to amounts expended on MAA in the form of private health insurance coverage under the new section the Federal medical matching percentage will be increased by 5%. For such health insurance expenditures Federal matching will run from 52½% to 84% as noted below:

Federal Medical Percentages Applicable for July 1, 1963 Through June 30, 1965

State	Percentage	State	Percentage
Alabama	78.29	Alabama	82.20
Alaska	50.00	Alaska	52.50
Arizona	58.75	Arizona	61.69
Arkansas	80.00	Arkansas	84.00
California	50.00	California	52.50
Colorado	50.00	Colorado	52.50
Connecticut	50.00	Connecticut	52.50
Delaware	50.00	Delaware	52.50
District of Columbia	50.00	District of Columbia	52.50
Florida	60.69	Florida	63.72
Georgia	73.69	Georgia	77.37
Guam	50.00	Guam	52.50
Hawaii	50.00	Hawaii	52.50

State	Percentage
Idaho	67.43
Illinois	50.00
Indiana	52.06
Iowa	57.63
Kansas	56.63
Kentucky	75.27
Louisiana	73.46
Maine	65.65
Maryland	50.00
Massachusetts	50.00
Michigan	50.00
Minnesota	56.42
Mississippi	80.00
Missouri	50.45
Montana	59.69
Nebraska	55.10
Nevada	50.00
New Hampshire	56.38
New Jersey	50.00
New Mexico	66.55
New York	50.00
North Carolina	74.99
North Dakota	73.03
Ohio	50.00
Oklahoma	65.65
Oregon	50.00
Pennsylvania	50.00
Puerto Rico	50.00
Rhode Island	50.90
South Carolina	80.00
South Dakota	68.87
Tennessee	75.53
Texas	61.45
Utah	62.28
Vermont	64.75
Virgin Islands	50.00
Virginia	65.05

State	Percentage
Idaho	70.80
Illinois	52.50
Indiana	54.66
Iowa	60.51
Kansas	59.46
Kentucky	79.03
Louisiana	77.13
Maine	68.93
Maryland	52.50
Massachusetts	52.50
Michigan	52.50
Minnesota	59.24
Mississippi	84.00
Missouri	52.97
Montana	62.67
Nebraska	57.85
Nevada	52.50
New Hampshire	59.19
New Jersey	52.50
New Mexico	69.88
New York	52.50
North Carolina	78.74
North Dakota	76.68
Ohio	52.50
Oklahoma	68.93
Oregon	52.50
Pennsylvania	52.50
Puerto Rico	52.50
Rhode Island	52.50
South Carolina	84.00
South Dakota	72.31
Tennessee	79.31
Texas	64.52
Utah	65.39
Vermont	67.99
Virgin Islands	52.50
Virginia	68.30

Existing Law		H.R. 3727, (Congressman Herlong) H.R. 3728, (Congressman Curtis) and others
State	Percentage	State	Percentage
Washington	50.00	Washington	52.50
West Virginia	71.76	West Virginia	75.35
Wisconsin	52.50	Wisconsin	55.13
Wyoming	50.00	Wyoming	52.50
(27 F.R. 9230)			
75 percent Federal matching is authorized for certain rehabilitation services for aged recipients and for the training of welfare personnel		Same as existing law.	
The Federal government pays 50 percent of administrative costs.			
Pass Along Provision. No provision in existing law to insure that public assistance recipients receive higher payments because of legislation liberalizing the Federal matching formula.		Same as existing law.	

E. STATE PLAN REQUIREMENTS

In order to be eligible for Federal participation, the State must provide medical assistance for the aged according to a plan submitted to the Secretary of Health, Education, and Welfare, and approved by him, which meets the requirements set out in the law. The State plan provisions are generally the same as those required for the other public assistance programs with the following exceptions:	The following changes are made in MAA state plan requirements:
A State plan --	
(1) must not require a premium enrollment fee, or similar charge, as a condition of eligibility;	(1) provides an exception with respect to assistance furnished in the form of health insurance coverage under the new section;
(2) must not impose property liens during the lifetime of the individual receiving benefits (except pursuant to court judgment on account of benefits in-	(2) Same as existing law;

Existing Law	H.R. 3727, (Congressman Herlong) H.R. 3728, (Congressman Curtis) and others
correctly paid) and any recovery provisions under the plan must be limited to the estate of the individual after his death and the death of his surviving spouse; (3) must not impose a citizenship requirement which would exclude a citizen of the United States or a requirement which excludes a resident of the State; (4) must also provide, to the extent required by the Secretary of Health, Education, and Welfare, for inclusion of residents of the State who are absent therefrom; (5) include reasonable standards consistent with the objectives of this title for determining eligibility for, and the extent of, assistance; and (6) if a State has both a program for old-age assistance and medical assistance for the aged it must be administered by a single State agency.	(3) Same as existing law; (4) Same as existing law; (5) Modified provision so that State plan must include reasonable income standards and that a statement of income under oath shall be accepted by the State agency (subject to penalties for fraud) as conclusive. (6) Provides that the State could designate one State agency to administer the portion of the State plan that relates to old-age assistance, and a separate State agency to administer the portion relating to medical assistance for the aged.

F. USE OF PRIVATE HEALTH INSURANCE

Includes in the amounts subject to Federal matching the expenditures for insurance premiums for medical or any other type of remedial care or the cost thereof.	Amend the provisions which describe the purposes of appropriations to include encouragement for "each state to provide medical assistance for all aged individuals through the utilization of insurance provided by private insurance carriers." Adds a new section under which a State with an MAA program would be authorized, in its discretion, to provide the MAA in the form of premium payments for health insurance coverage under voluntary private health insurance plans in addition to providing the assistance in the manner authorized under existing law. A State wishing to participate in the program would be required to enter into contracts or other arrangements with private insurance carriers as it deems appropriate.

Existing Law

H.R. 3727, (Congressman Herlong)
H.R. 3728, (Congressman Curtis) and others

The contracts would have to: (1) be guaranteed renewable; (2) provide benefits which, together with MAA benefits authorized in existing law, include both institutional and noninstitutional care; (3) establish enrollment periods not less often than once a year; and (4) contain such other provisions as the state agency determines are necessary to carry out the purposes of the program.

If a State provides an MAA program in the form of health insurance coverage, the same coverage would have to be available to all individuals who reside in the State and who are 65 or over.

Provides that premiums for coverage of any individual under an insurance plan would be paid by the State agency with the following two exceptions. The State agency could establish a maximum income level at least equal to the highest level at which an individual may qualify under the MAA program in the State. If the individual's income is above this level, the premiums would be paid in part by the individual and in part by the State agency in proportions based on the individual's income as the State agency may determine up to a higher income level as the State agency determines to be appropriate. If the individual's income is above the higher level, he would be required to pay the premium in full.

For the purposes of the section "income" would include gross income as defined under the Internal Revenue and in addition any interest, rents, annuities, and other retirement payments from any source which are not includible in gross income as so defined.

Existing Law

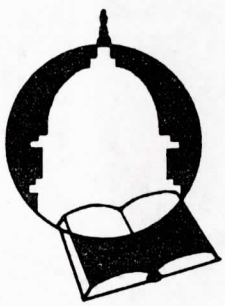
H.R. 3727, (Congressman Herlong)
H.R. 3728, (Congressman Curtis) and others.

Each individual covered under an insurance plan under the program would be required to certify his income to the State agency in a manner and at such times (but at least once a year) as the State agency may require. The State agency would be required to accept the certification as conclusive. The certification would be subject to the penalties for fraud under the Social Security Act.

APPENDIX C

THE LIBRARY OF CONGRESS
LEGISLATIVE REFERENCE SERVICE

BRIEF ANALYSIS OF
H.R. 4351 -- "COMPREHENSIVE HEALTH INSURANCE ACT FOR THE AGED"



Education and Public Welfare Division
February 16, 1965

Washington 25, D.C.

H.R. 4351 -- "COMPREHENSIVE HEALTH INSURANCE ACT FOR THE AGED"

Byrnes Bill -- H.R. 4351, Utt Bill -- H.R. 4352, Betts Bill -- H.R. 4353, Schneebeli Bill -- H.R. 4354, Collier Bill -- H.R. 4355

I. GENERAL DESCRIPTION

Provides on voluntary basis to persons 65 or over benefits comparable to high-option Governmentwide Indemnity Plan for Government employees. Persons under social security (or railroad retirement) would pay premium scaled to their monthly social security benefit or, if not actually drawing benefits, would be deemed to have paid premium. Persons not under social security would pay premium equal to maximum premium payable under social security. Premium rates increased if individuals enroll after initial enrollment period provided for them. States may purchase insurance for OAA and MAA recipients at group rate. Remainder of cost of program to be financed from Federal general revenues.

Secretary of Health, Education, and Welfare to administer health insurance program acting through Surgeon General. Secretary of the Treasury to administer Comprehensive Health Insurance Fund for the Aged.

II. BENEFITS

Benefits would consist of cash payments to insured (unless he instructs direct payments to providers of service) in any one calendar year[1/] for reasonable and customary charges as follows:

(1) payment of first $1,000 of expenses for room and board in hospital or nursing home and of 80 percent of balance of such expenses. (no deductible)

(2) after a deductible, payment of 80 percent of other inpatient and outpatient hospital (or nursing home) expenses for which hospital charges in own behalf (drugs, operating room, etc.) and of surgical and medical services and supplies (doctors' and nurses' fees regardless of where service rendered, ambulance service, drugs, emergency dental work, etc.).

Deductible must be made up of allowable items under one or both of categories "other hospital expenses" and "surgical and medical expenses." Maximum deductible in a calendar year is $50. This maximum must be met before surgical or medical expense benefits are paid by plan. Benefit payments under "other hospital expenses" may begin after deductible totals $25.

(3) charges of Christian Science practitioner allowed if insured so elects.

(4) program calls for lifetime maximum of $40,000. However, if payments made against this sum, amount remaining payable to person over

1/ 12-month period beginning January 1 and terminating following December 31. For newly covered person, calendar year begins when coverage begins and runs through December 31 of same year.

his lifetime restored to $40,000 or increased by $1,000, whichever is smaller, in following year. Maximum may be restored to $40,000 even if has been reduced by more than $1,000 upon satisfactory evidence of insurability.

(5) payment for services of doctors and psychologists and for prescribed drugs for treatment of mental and nervous disorders of individuals not hospital inpatients is limited to $250 or to 50 percent of such expenses, whichever smaller.

(6) maximum benefits in calendar year for person confined to hospital or nursing home on date he comes under program is $1,000. Limitation removed when he has been free of confinement for 31 consecutive days.

III. ELIGIBILITY

Any person who --

(1) has attained age 65, and

(2) is a resident of the United States and is either a citizen or alien lawfully admitted for permanent resident and has not been convicted of certain subversive activities, and

(3) enrolls (other than public assistance recipients enrolled by the State) either --

(a) during initial enrollment period, which is period of up to 6 months following month program is enacted for persons who are 65 or over (at time of or within 3 months of enactment) and which is for all other persons a period of 3 months prior to and 6 months after the month they become 65,

or

(b) during a general enrollment period, which is period of 3 consecutive calendar months prescribed by Secretary of Health, Education, and Welfare, but at least 2 years must elapse between general enrollment periods.

IV. FINANCING

Program would be financed by premiums paid by individuals, by States on behalf of aged public assistance recipients, by appropriations from Federal general revenues, and to a limited extent, from OASI trust fund and railroad retirement account.

(1) Individuals receiving or entitled to receive (i.e., have applied for) social security or railroad retirement benefits would pay monthly premium equal to 10 percent of minimum monthly cash social security benefit of a primary beneficiary plus 5 percent of additional cash benefit paid to primary beneficiary and his spouse if aged 65 or over.

Monthly benefit on which premium is based is before any reduction in benefit due to factors such as retirement test. Premiums would be deducted from monthly cash benefits. If benefit less than amount of premium, difference would be "deemed" to have been deducted from benefit.

(2) For individuals who are eligible but have not applied for social security or railroad retirement benefits, health insurance premiums would be based on monthly benefit they would be entitled to if they had applied for benefits in month in which enrolled in insurance program and would be "deemed" to be deducted.

(3) Person not entitled to or eligible for social security or railroad retirement benefits would pay premium based on maximum social security benefit for an individual.

(4) Premium rates increased as following for persons who enroll in program after their initial enrollment period has elapsed.

If participation begins	Percent increase would be
Before attain age 68	10
After attain 68, before attain 70	20
After attain 70, before attain 72	30
After attain 72	40

(5) States may make arrangements with Secretary of Health, Education, and Welfare to cover in health program persons eligible for OAA, MAA, or aid to aged, blind, or disabled (consolidated program)2/. Monthly premium State would pay for each such individual would be average monthly premium deducted from social security beneficiaries for health insurance (as described in (1) above) as of June in each odd-numbered year.

(6) Federal Government would appropriate to health insurance fund necessary funds to insure--

(a) prompt payment of benefits;
(b) payment of administrative expenses payable out of the fund; and
(c) maintenance of proper contingency reserve in such fund.

V. ADMINISTRATION

Secretary of Health, Education, and Welfare to administer health insurance program acting through Surgeon General. To maximum extent possible, he is to enter into contracts with carriers for them to process and pay claims.

2/ Agreement may exclude coverage of persons in these groups who are entitled or upon application would be entitled to social security or railroad retirement benefits.

Secretary of the Treasury to hold and manage Comprehensive Health Insurance Fund for the Aged, a trust fund on books of Treasury to which will be transferred from OASI Trust Fund and Railroad Retirement Fund premiums that were deducted or "deemed" deducted from monthly cash benefits, and appropriations from general revenue.

VI. EFFECTIVE DATE FOR BENEFITS

To cover expenses incurred on and after January 1, 1966.

APPENDIX D

THE LIBRARY OF CONGRESS
LEGISLATIVE REFERENCE SERVICE

CHRONOLOGY OF MAJOR DEVELOPMENTS WITH RESPECT TO THE MEDICAL CARE FOR THE AGED ISSUE DURING THE 88TH AND THE OPENING DAYS OF THE 89TH CONGRESS

[To be used with the introduction to "Medical Care for the Aged: A History of Current and Past Proposals and Pro and Con Arguments"]

Education and Public Welfare Division
January 13, 1965

Washington 25, D.C.

CHRONOLOGY OF MAJOR DEVELOPMENTS WITH RESPECT TO THE MEDICAL CARE FOR THE AGED ISSUE DURING THE 88TH AND THE OPENING DAYS OF THE 89TH CONGRESS

88th Congress

On February 1, 1963, in his Message on Elderly Citizens of our Nation, (House Doc. no. 72, 88th Cong., 1st sess.), President John F. Kennedy called for enactment of a hospital insurance bill under the old-age, survivors, and disability insurance system (Social Security). On February 21, 1963, Congressman Cecil King (H.R. 3920) and Senator Clinton Anderson and 32 other Senators (S. 880) introduced the Administration bill.

Following the vote of the Senate in 1962, Senator Jacob K. Javits had announced that he had been instrumental in the establishment of a National Committee on Health Care of the Aged, with Arthur S. Flemming, former Secretary of Health, Education and Welfare as Chairman. Included also in its membership was another former Secretary of the Department, Marion Folsom. Their report, "Financing Health Care of the Aged," appeared on November 13, 1963, and formed the basis of a new Javits bill (S. 2431) which was introduced on January 16, 1964. This bill contained provisions similar to the King-Anderson bill but provided also for a program of complementary health care benefits for the aged -- medical, surgical, and related services -- through the establishment of a national association of private insurance carriers to make available to aged persons a nonprofit, tax-exempt standard health insurance policy at reasonable cost.

Meanwhile, the Committee on Ways and Means of the House announced that two weeks of hearings on the King-Anderson and other bills would

be held beginning November 18, 1963. These hearings were interrupted by the assassination of President Kennedy on November 22nd, and resumed on January 20th to continue through January 24th. Congressman Frank T. Bow testified in favor of his bill (H.R. 21) which, again in this Congress, used the tax credit method for the cost of prescribed plans purchased by or on behalf of persons 65 and over. Congressman John Lindsay appeared in favor of his proposal (H.R. 9732) which used the Social Security method to provide a choice of substantially the same benefits in the King-Anderson bill, or a private health benefit option under which an individual could assign part of his monthly cash payment to the carrier of his private health benefits plan. Administration was to be at the State, rather than the Federal, level and the aged who could not qualify under Social Security were to be blanketed in by combined State and Federal matching, with participation for the uninsured group optional with the States.

On January 21, 1964, in his State of the Union Message (House Doc. 251, 88th Cong., 2nd sess.) and again in his "Message on Health" on February 10, 1964 (House Doc. 224, 88th Cong., 2nd sess.), President Lyndon B. Johnson described the Administration bill as "urgently needed" legislation.

On April 1, 1964, Senator Saltonstall and four other Senators (Beall, Cotton, Morton, and Scott) introduced another alternative (S. 2705), which very briefly, sets forth a choice of three health care plan options (one private) which, using joint Federal-State

matching, would provide benefits for aged individuals with incomes of not more than $3,000 a year ($6,000 for a couple) with a minimum annual enrollment fee of $10 and a maximum (depending upon income) of $120. Administration would be at the State level.

On April 24, 1964, Senators Scott and Fong introduced a further alternative (S. 2771) which would have established a voluntary Federally-administered (Secretary of Health, Education and Welfare) health insurance program under which the Federal Government would make payments up to $90 a year to or on behalf of persons aged 65 or over toward purchase of a qualified private health insurance policy for which they were beneficiaries. Participants could choose between a short-term illness and a long-term illness benefit policy.

On April 8, 1964, the Committee on Ways and Means went into executive session on Medical Care for the Aged, and other aspects of the Social Security System.

On July 7, 1964, the Committee on Ways and Means reported out the Social Security amendments of 1964 (H.Rept. 1548, 88th Cong., 2nd sess. on H.R. 11865) which contained, among other provisions, a 5% across-the-board increase in benefits, but no provision affecting either medical care under the social security system or the existing Kerr-Mills law. A press release setting forth a summary of the committee's action, dated June 25, 1964, stated, however: "It was understood and agreed by the committee that the foregoing changes in title II of the Social Security Act would be made without prejudice to possible action at a future time on the subject of hospital

insurance under social security or on the subject of amendments to the medical assistance for the aged under title I of the Social Security Act."

On July 29, 1964, the bill was debated in the House on a closed rule and was adopted as reported by the Committee by a vote of 338 yeas, 8 nays, and sent to the Senate. (Cong. Record Daily, pp. 16668-16720.)

On August 6, 1964, the Committee on Finance of the Senate opened hearings on the Social Security bill (H.R. 11865) as passed by the House, together with amendments to the bill which had been introduced in the Senate providing medical care for the aged. The hearings continued through August 14th. Those amendments were:

1. The Gore-Anderson amendment (the King-Anderson bill), introduced by Senator Gore, and others, on behalf of Senator Anderson and the Administration.

2. The Ribicoff (and others) amendment which:
Contained similar provisions, under the Social Security and Railroad Retirement systems, and for the uninsured, with major differences noted below.
- Removed the 5% benefit increase from the House bill.
- Provided a $7 a month increase in benefits for all primary beneficiaries, effective for months after June 1965. However, the increase for persons 65 or over was not effective unless irrevocably elected. If election of full cash benefit was not made, the bill provided health insurance benefits (hospital, nursing home, visiting nurse) with reduction of cash benefit by $5 for every beneficiary entitled.
- If hospital costs rise after 1965, and the earnings base is not changed proportionately, in 1969 beneficiaries of hospitalization would be charged a daily amount equal to the differential between the national average per diem rates in 1964-65 ($36) and the average per diem rate for the 2 years prior to 1969. This adjustment process would be followed every 2 years thereafter to take into account any later hospital cost increases.

- The Secretary of Health, Education and Welfare was directed to enter into an agreement with a nationwide organization for it to carry out administrative functions of the health insurance program.

3. The Javits (and others) amendment which was substantially the same as S. 2431 introduced on January 16, 1964, (previously described) except that, as to the 5% cash benefit increase in the House bill, provided that no person would be entitled to health insurance benefits unless he signed a certificate irrevocably electing such benefits and agreed to take a 5% reduction in cash benefits.

The Social Security amendments as reported to the Senate on August 20, 1964, (S. Rept. No. 1513, 88th Cong., 2nd sess.) contained no provision for medical care for the aged, proposals to report out both the Gore and Ribicoff amendments having been rejected by a vote of the Committee members.

On August 21, 1964, the Scott-Fong amendment, which was substantially the same as S. 2771 (April 24, 1964), was introduced.

The bill as reported by the Committee on Finance was debated in the Senate on August 31st, September 1, 2, and 3, 1964. The "divided time" debate, which occurred under an unanimous consent agreement on September 2, 1964 (Cong. Record Daily, pp. 20630-60) to consider a revised Gore-Anderson amendment (including the Javit's complimentary private insurance plan) includes the major arguments which had appeared for and against the proposal. Following this debate, the amendment was adopted by a vote of 49 yeas to 44 nays. (See attached explanation for details) Following this vote the Scott-Fong amendment was defeated by a voice vote on September 2, 1964 (p. 20687).

The Conference Committee between the House and Senate on the Social Security amendments had its first meeting on September 16, 1964,

and, after more than two weeks of consideration of all phases of the bill, adjourned on October 2, 1964, without agreement, the Senate conferees voting to insist on the adoption of the Gore-Anderson-Javits amendments, and the House conferees voting to refuse to adopt it.

The Hon. Wilbur Mills, Chairman of the Committee on Ways and Means and Chairman of the Conference Committee, stated on October 3, 1964, on the floor of the House of Representatives, that the conference decision, like the action of the Committee on Ways and Means was "without prejudice to possible action at a future time on the subject of hospital insurance under social security or on the subject of amendments to the medical assistance for the aged under title I of the Social Security Act."

He also stated at that time:

> It was also my thought in conference that the Committee on Ways and Means should resume consideration of the medical care problems of the aged next year. Any provisions for medical care for the aged could have been made available just as early as had been provided in the Senate amendment on hospitalization insurance benefits. However, as it developed, it was not possible to obtain this result. (Cong. Record Daily, October 3, 1964, p. 23224)

During the Presidential campaign, President Johnson stated that "medicare" was on the "top of the list" of his "must" legislation and this was reemphasized by him after he was reelected in November.

Opening days of the 89th Congress

The Report of the second Advisory Council on Social Security,[1] appointed in 1963 under the Social Security Amendments of 1956 (which also specified that such representative Councils should be appointed in 1966 and every fifth year thereafter), appeared on January 3, 1965. With respect to the issue of Medical Care for the Aged the Council recommended a program of hospital insurance for the aged Social Security eligibles and younger disabled workers which would provide for up to 60 days of hospital care per illness, with a deductible equal to the cost of one-half day of care (about $20 now); 30 days of care in a hospital-operated or -affiliated extended care facility with 2 additional days for each day the patient's hospital stay was under 60 days; "a substantial number of organized home nursing service visits -- in the range of two or three hundred a year" when medically supervised and provided through qualified nonprofit or public agencies; and out-patient diagnostic services with a deductible equal to the deductible of inpatient hospital services for each 30-day period. Their proposed plan would be financed by a separate, ear-marked payroll tax, using

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1/ The Membership of the Council was as follows: Robert M. Ball, Commissioner of Social Security, Chairman; J. Douglas Brown, Dean of the Faculty, Princeton University; Kenneth W. Clement, M.D., Practicing Physician and Immediate Past President, National Medical Association; Nelson H. Cruikshank, Director, Department of Social Security, American Federation of Labor and Congress of Industrial Organizations; James P. Dixon, M.D., President, Antioch College; Loula F. Dunn, Director, American Public Welfare Association, 1949-64; Marion B. Folsom, Director and former Treasurer, Eastman Kodak Company; Gordon M. Freeman, President, International Brotherhood of Electrical Workers; Reinhard A. Hohaus, Director, Metropolitan Life Insurance Company and Fellow, Society of Actuaries; Arthur Larson, Director, Rule of Law Research Center, Duke University; Herman M. Somers, Professor of Political and Public Affairs, Princeton University; John C. Virden, Chairman of the Board, Eaton Manufacturing Company; and Leonard Woodcock, Vice President, United Automobile, Aerospace and Agricultural Implement Workers of America.

coverage and maximums recommended also for the cash benefits program, including an earnings base of $6,000 in 1966 rising to $7,200 in 1968. In addition to the separate payroll tax, the Council recommended contributions from Federal general revenues (equal to 0.15% of covered payroll for 50 years) to help finance the plan as to individuals already retired, disabled workers, and the uninsured elderly.

On the opening day of the 89th Congress (January 4, 1965) Congressman King introduced H.R. 1 which provided a benefit package roughly equivalent to the Advisory Council recommendation but did not extend health insurance benefits to disabled workers. Moreover, it did not provide a separate payroll tax and the maximum taxable wage base would be raised to only $5,600 a year. An identical bill (S. 1) was introduced in the Senate by Senator Anderson and 43 co-sponsors on January 6, 1965 (See attached explanation for details). Congressman Bow also reintroduced his bill using the tax credit method (H.R. 21) on the opening day (January 4th).

On January 6, 1965, Senator McNamara also introduced a bill (S. 65) which set up a separate tax on earnings up to $9,000 a year to finance a program of 45 days of hospital care, 90 days of nursing home care, 120 days of home health services, and outpatient services with a $10 deductible for each 30-day period for the aged 65 and over. As in his previous bills general revenue financing was authorized for the uninsured aged group. And on January 11, 1965 Senator Saltonstall (for himself and Senators Aiken, Cotton, Morton, and Scott) introduced S. 394 which is substantially the same as the Federal-State grant-in-aid

health insurance bill which he introduced in the 88th Congress as S. 2705.

The President's Special Message on Health, "Advancing the Nation's Health," which appeared on January 7, 1965, named as its first recommendation the following:

> I ask that our Social Security system -- proved and tested by three decades of successful operation -- be extended to finance the cost of basic health services. In this way, the specter of catastrophic hospital bills can be lifted from the lives of our older citizens. I again strongly urge the Congress to enact a hospital insurance program for the aged. Such a program should:
>
> - Be financed under social security by regular, modest contributions during working years;
> - Provide protection against the costs of hospital and post-hospital extended care, home nursing services, and outpatient diagnostic services;
> - Provide similar protection to those who are not now covered by social security, with the costs being paid from the administrative budget;
> - Clearly indicate that the plan in no way interferes with the patient's complete freedom to select his doctor or hospital.
>
> ...
>
> Also, I urge all States to provide adequate medical assistance under the existing Kerr-Mills program for the aged who cannot afford to meet the noninsured costs.

Chairman Mills has indicated that there will be early consideration by the Committee on Ways and Means, where such legislation must originate, of health care for the aged proposals.

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BRIEF ANALYSIS OF SALTONSTALL HEALTH INSURANCE FOR THE AGED BILL (S. 395, 89th CONGRESS)

Introduced by Senator Saltonstall
and Senators Aiken, Cotton, Morton, Prouty and Scott
(January 12, 1965)

I. GENERAL DESCRIPTION

A voluntary State-administered health insurance program for persons 65 years of age or older with low or moderate incomes. Eligible participants may choose one of three options -- a first-dollar short-term program; a deductible and co-insurance long-term program; or payments towards a qualified private insurance policy.

Program to be financed under Federal-State grant-in-aid matching mechanism and by enrollment fees related to income of participants. Program available only to States with MAA program in effect.

II. BENEFITS

State plan must offer choice among 3 actuarially equivalent programs:

(a) Preventive, diagnostic and short-term illness benefits
Under this option the plan must provide participants during any enrollment year[1] with at least the following minimum benefits:

(1) inpatient hospital services up to 21 days
(2) skilled nursing home care, up to 63 days (number of hospital days to be reduced 1 day for each 3 days of skilled nursing home care)
(3) surgical services provided in a hospital
(4) physicians' services for 12 days outside a hospital
(5) ambulatory diagnostic laboratory and x-ray services rendered outside a hospital or nursing home, up to $100.

Additional health benefits could be provided.

(b) Long-term illness benefits
Under this option, the plan, after a $50 annual deductible, would pay not less than 80% nor more than 90% of the following benefits:

(1) inpatient hospital service, up to 120 days
(2) skilled nursing home care

1/ Enrollment year is a period of 12 consecutive months so designated by the State agency in accordance with regulations prescribed by Secretary of Health, Education, and Welfare.

(3) prescribed drugs
(4) diagnostic laboratory services, including x-ray, up to $200
(5) outpatient hospital services
(6) physicians' services, including surgery.

Additional health benefits could be provided.

(c) Private insurance policy program
Under this option, payment is made to insurance company or policyholder towards defraying cost of qualified private health insurance policy. Payment in an enrollment year may not exceed actuarial value (average per capita cost including administrative costs) of short-term or long-term program minus enrollment fee individual would have paid had he chosen one of the other two programs.

Benefits under private policy must have actuarial value at least equal to that of benefits provided by either the short-term or long-term programs.

Private health policy must be guaranteed renewable for life. Changes in rates must apply to all members of plan or a broad class of persons thereunder.

III. ELIGIBILITY
Persons who--

(a) are age 65 or over and reside in the State; and
(b) are not recipients of any other Federal public assistance program (MAA excluded from this limitation); and
(c) have an annual income of $3,000 or less if unmarried or a combined income of $6,000 or less if married and living with spouse. Income defined as adjusted gross income plus benefits from Social Security, Railroad Retirement, and Veterans' pension.

OR, at option of State

(d) if they do not meet income requirements

(1) were enrolled in preceding enrollment year; and
(2) meet conditions of eligibility for persons not meeting income requirements (including payment of increased enrollment fee)

States: Must have Medical Assistance for the Aged program in effect to participate in insurance program.

IV. FINANCING

Individuals: For short-term and long-term plans individuals pay an annual enrollment fee that varies with income as follows:

Annual Income of Individual	Amount of Enrollment Fee
1. $1,000 or under	$10
2. More than $1,000, not more than $1,500	$10 plus 2½% of income in excess of $1,000
3. More than $1,500, not more than $2,000	$22.50 plus 3½% of income in excess of $1,500
4. More than $2,000, not more than $2,500	$40 plus 7% of income in excess of $2,000
5. More than $2,500, not more than $3,000	$75 plus 9% of income in excess of $2,500

For purpose of applying this schedule to a married individual, his income is considered to be half of the couple's combined income. (A spouse who is under age 65 does not qualify but income would be considered in determining aged individuals enrollment fee.)

The enrollment fee for a person with an income in excess of $3,000 who still is qualified to participate (see section on eligibility) is $120 plus any additional amount the Secretary of Health, Education and Welfare may prescribe.

State and Federal: Depending upon its per capita income, a State would receive from the Federal Government from 60 to 80 percent of the non-administrative cost of the program in excess of the amount covered by enrollment fees up to a maximum of $150 per enrollee. Administrative costs would be shared equally between the Federal and State Governments. Federal portion financed from general revenues.

V. ADMINISTRATION

Federally approved State plan to be administered by a single State agency. State may utilize services of voluntary private organizations in administration of plan except for collection of enrollment fees.

Education and Public Welfare Division
January 19, 1965

APPENDIX F *

TO ALL MY PATIENTS:

I believe it is my responsibility as a physician to call to the attention of my patients any matter which I feel would affect their health care.

Therefore, I want to discuss a proposal about which I am deeply concerned.

It is a proposal now before Congress. It is called the King-Anderson Bill. If enacted into law, it would provide some medical care for the aged over 65 who are eligible for social security.

On the surface the bill sounds pretty good, doesn't it? But let me tell you what is in the *fine print*.

- It calls for a "double increase" on payroll taxes—an increase in the per cent of tax take, plus an increase in tax base. Employees and employers each would be paying 17 per cent *more tax* than they pay today.
- It would compel wage-earners to pay for medical care for millions of the aged who don't need help . . . but the proposal does nothing for millions not covered by social security—the group most in need.
- It is a compulsory, Federal government-controlled plan which would place a third party—Washington bureaucrats—between the patient and the physician. It would place politics at the bedside of the ill.
- It would limit the patient's free choice of hospital and physician.
- It would eliminate the privacy of the patient-physician relationship . . . making it possible for government clerks to examine the most intimate personal health records—records that are now a private matter between patient and physician.
- It would definitely lower the quality of medical care.
- It would be the first step toward socialist medicine in this country . . . a system that has resulted in the deterioration of medical care wherever it has been tried.

If you feel as I do, it is my hope that you will convey your thoughts to your Senators and your Congressman, as I have done.

If you have any further questions on this issue I will be happy to discuss them with you.

Working together, we can preserve the high quality of medical care now available in this country.

Let's keep politics out of medicine.

Your Doctor

* This type of literature was distributed by doctors in 1962.

OPERATION HOMETOWN

Appendix G

FIVE MINUTES-FIFTEEN POINTS

Short Talk for Public Audiences

on

Health Care for the Aged

Time: 5 minutes

American Medical Association
535 North Dearborn Street
Chicago 10, Illinois

(Note to speaker: This is a 5-minute speech, for use on occasions when you are not the main speaker but might be called upon for some brief remarks.)

I promised to talk not more than five minutes, and I intend to keep that promise.

My purpose here today is simply to outline 15 basic facts--15 reasons why you, and all Americans, should oppose the King-Anderson Bill now before the 88th Congress.

This proposal would use increased Social Security taxes, plus some general tax funds, to provide certain limited health care benefits for all people over age 65. With only minor, superficial variations, this is the same plan which last year was defeated in the U. S. Senate and rejected by American public opinion.

Here are the 15 points which I think you should consider:

1. The great majority of Americans over 65 are not poor, ill and without proper health care.

2. Both the health and finances of our senior citizens are far better than they have been pictured, and they will be improving constantly in the years ahead.

3. The medical cost problems that do exist among the aged are problems of individuals, not of an entire age group.

4. Those problems can be met most efficiently and economically by methods which fit individual needs and the great variety of state and local situations.

5. Our nation already has voluntary, flexible programs to accomplish that purpose. The job now is to expand and improve them.

6. One of those programs is the Kerr-Mills Law, which Congress passed in 1960. This law enables the states to provide a wide range of health care benefits for all people over 65 who need help.

7. Under the Kerr-Mills Law, 38 states and territories already have improved or expanded their Old Age Assistance medical programs, and 31 have established new medical assistance programs for old people who are not on public assistance. The medical profession is working actively to promote full, efficient use of the Kerr-Mills Law in all states which need it.

8. The other existing method is voluntary health insurance and prepayment plans, which already protect more than 55 per cent of our senior citizens. New plans and ideas are developing at a fast pace, and within the next three years voluntary plans are expected to be protecting 70-75 per cent of the people over 65.

9. By promoting full use and development of these tools already at hand--which is the path of common sense--we can avoid the faults and dangers of the King-Anderson type of program--which is the path of common vote-grabbing politics.

10. This proposal, offering limited hospital, nursing home, and home nursing benefits, would meet neither the medical nor the financial needs of the old people who really need help.

11. It would scatter those limited benefits, at public expense, to millions of people over 65 who neither need nor want such help, and who are willing and able to stand on their own two feet.

12. It would raise Social Security taxes on all workers--young and old--to provide these limited benefits for just one age group...and the cost of the program would be at least double what the people are being told.

13. It would alter radically the whole purpose and nature of our American system of Social Security, which is based upon cash benefits.

14. It would be the first major step toward government medicine for our entire population--with all the resultant evils of assembly-line care dished out according to federal regulations.

15. Its enactment would have an ominous, far-reaching influence on the entire social, economic and political future of our nation.

Those are my 15 points. But don't just take my word for it. I ask only that you study carefully all the facts, realities and viewpoints involved in this issue. If you do, I am confident that the great majority of you will agree with me.

When you make up your mind, I urge you to write your opinions to your two U. S. Senators and to your Congressman in Washington. That is where the issue will be decided.

You can help see to it that the decision is based upon common sense rather than common politics.